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JANUARY—FEBRUARY, 1957

VOL. 11, NO. 1

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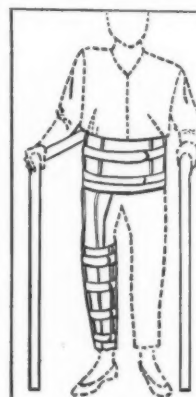
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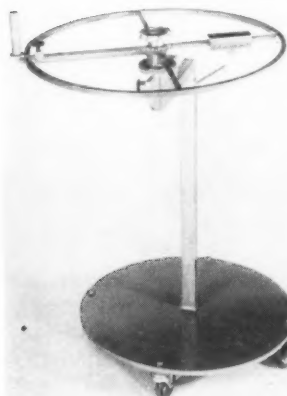
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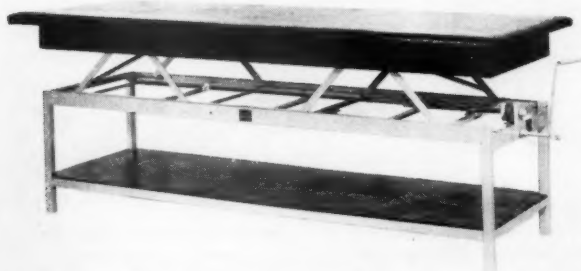
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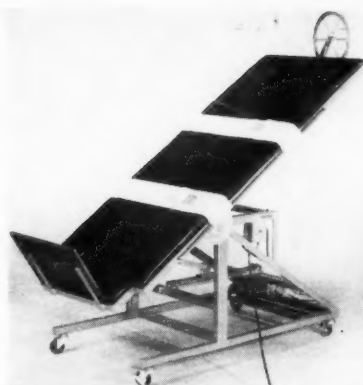
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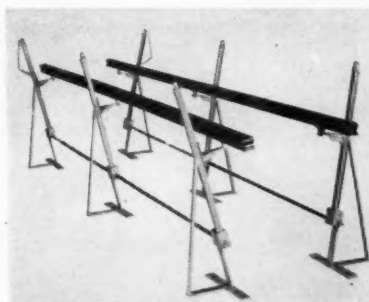
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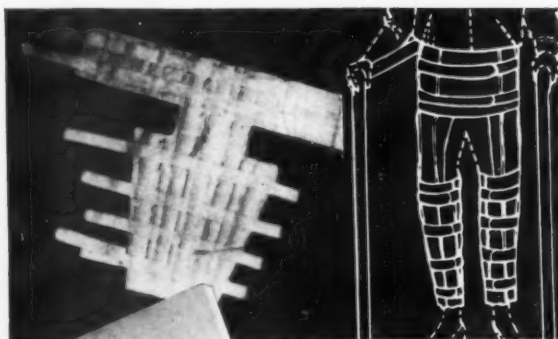
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ARTICLES

The Patient and His Motivation — Norman Q. Brill, M.D. 5

Integrative Field Work Experiences for Pre-Therapists —
Carl Haven Young, Ed.D. 11

Human Relations in Corrective Therapy — Raymond B.
Heaslet 17

DEPARTMENTS

CONFERENCE REPORT 20

FROM OTHER JOURNALS 23

EDITORIALS 25

BOOK REVIEWS 26

NEWS AND COMMENTS 29

OFFICIAL REGISTRY 32

CLASSIFIED DIRECTORY Back Cover

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THE PATIENT AND HIS MOTIVATION*

NORMAN Q. BRILL, M. D.**

Health is usually looked upon as a priceless asset—one that makes possible the utmost enjoyment of life and the greatest opportunity to achieve worthwhile objectives whatever they may be. It is generally assumed therefore, that any sick person will desire to have his health restored and will actively cooperate in measures that are prescribed to restore his health.

Anyone who works with sick people knows this is not always the case. Much too often do we encounter patients who seem to *not* want to get well, who in one way or another frustrate the efforts of their families or others who seem intent on helping them.

There are a few instances where patients consciously dread the treatment more than the illness and even though there is a marked neurotic component in these cases, they don't appear too abnormal to the average person. For example, a person may neglect a decaying tooth because of fear of the dentist, or avoid an operation because of fear of surgery. Usually when the suffering becomes great these patients seek help, even if reluctantly or with great fear. It is not these patients that I shall be discussing but those with a more malignant type of disorder.

It must be very frustrating to be working in the field of rehabilitation and to be constantly meeting up with clients who give the unmistakable impression that they don't want to be rehabilitated despite a veneer of cooperation and interest. When Mr. Gull-edge of the Vocational Rehabilitation Bureau asked me to talk on the subject of the client and his motivation, I suspected that he and his co-workers were having more than their share of such "customers," and I asked him to send me a few sample cases to whom I might tie my discussions. I want to make clear from the start that I have plenty of my own—taken from the practice of psychiatry, and while the basic problem is the same in his cases and my own, I feel that his kind might be of more general interest to such a meeting.

One of his clients was an 18-year old girl who had just graduated from high school. She was of Mexican extraction, and both of her parents were disabled, the family being on relief. Her left arm and hand were paralyzed and atrophied from an injury to her brachial plexus at birth; she was of low average intelligence with a poor capacity to reason and to read, and despite her high school education, she had no special skills. She maintained a passive, disinterested attitude about going to work and managed to frustrate all efforts (and there were many) to assist her in getting employment. She ended up by staying at home, presumably to take care of her sister's children and her mother.

Another case was that of a 21-year old boy with dull normal intelligence who had a tuberculous pleurisy. His mother was "on relief" and he said that as long as he was dependent upon her, she received a larger monthly check. He wanted a job that paid more than his level of performance would warrant, and he solved his problem by doing nothing.

A third example is that of a 44-year old divorced woman of Mexican extraction who had two children, aged 11 and 13, at home with her. Her husband was an alcoholic who never supported her and she was "on relief." She claimed she had always been sick, that she "had a spot on her heart that the doctors didn't tell her about," and that she "had rheumatism since childhood that was worse now." She complained of "trouble with her eyes," of pain in her chest, shortness of breath and of tiring easily. She claimed to have been operated upon for cancer of her female organs—which was not so—she had a chronic cervicitis. She would eat well when her relief check came—well enough to be obese—and then at the end of the month, had little money for food for herself or her children. She had the not uncommon experience of having her symptoms attributed at different times to refractive errors which caused poor vision, to the menopause, to poor teeth, etc. She, too, was found to be of low normal intelligence. She had gone to the fifth grade in school and was inclined to do violence to the truth. All efforts to help her failed. (I have not gone into the very great effort and all the time and attention that were put into each of these cases without effect.)

These are the kinds of individuals who, when given glasses to help their vision, lose them, break

*Presented at the California Conference on Health, Welfare and Recreation, May 9, 1956, Long Beach, California.

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them, or insist they don't help. When given training, they manage not to complete it; when a job is obtained for them, they invariably fail. Even short exposure to such clients convinces one that the loss or failure is no accident—no matter of hard luck. It is a well-designed, purposeful, consistent, forceful (although unconscious) plan to fail. Where does this drive come from and what does it mean?

To begin with, the phenomenon is not an unusual one. It is seen in a wide variety of socio-economic situations although the manifestations and severity may vary. It is seen in the compensation neuroses, in draftees in the army in war and peace, in wives of alcoholics, in the alcoholics themselves, and in fact, in many of the disabling neuroses. Dealing with the general topic of health education Bauer¹ asks the question, "Can there be values greater than the mere attainment of health?" He points out that one reason why we have not been more successful in directing people toward healthful living is that subconsciously many have decided, and quite correctly, that there are more important things than merely being healthy—or that the price of health is too high if it is to be acquired at the cost of doing or not doing all the things that the health educator advises or prohibits. There are many things we all do which we would not do were we thinking just of our health. A person may decide he would rather smoke and live six months less, or be fat and sacrifice a few years rather than live longer in the less interesting future.

This same mechanism to an exaggerated degree may be operating unconsciously in the poorly motivated patient and it might be well at this point to consider some of the factors which have bearing on motivation in general.

1. *Strength of drive or energy output:* To some extent individuals differ in their constitutional endowment. Some from birth are seen to be more passive than others. Some seem to have a greater availability of energy and greater potential output than others. Mothers will describe great differences in their children and nurses who work with newborns can easily distinguish differences in energy output and aggressiveness among the infants. Some move more than others, cry louder, go after food more actively. Whether or not these differences persist to adulthood and account for marked differences in adults is not known.

2. *Cultural differences:* Whatever the cause, marked differences exist in the drive of one culture as compared with another. Consider for example, the caricature of the American Indian on a reservation, or a Mexican peon with that of a New England farmer or a prospector.

3. *Ego ideal and cultural ideal (particularly as*

they relate to health and activity versus ill health, passivity and dependence): The child raised in a family in which there is competition for neurotic ill health and passivity may or may not absorb some of these attitudes. Illness may from early childhood become the accepted and preferred solution to the stresses, both internal and external, that are part of life and growing up. Consider, for example, the first case—the 18-year old girl with the atrophied arm who had before her the example of two disabled parents who depend on the Government for support. Compare this with the individual raised in a family where illness was considered a weakness and where success and accomplishment were the idealized goals. With health, as with other things, different individuals have different expectations for themselves and where expectations are the same some take active steps to achieve them and some dream about them and await their arrival.

4. *Intelligence:* Intelligence is another factor which plays a role in motivation. It is not accidental that all three cases that I have cited had low levels of intelligence. Individuals with less than normal levels to begin with are at a disadvantage in competing and in dealing constructively with life stresses. With less ability to plan or to predict they are more apt to be passive and accepting. Experience has shown that mentally retarded individuals are more apt to resort to neurotic illness in the face of danger. Many times during the war I thought of writing an article entitled, "Ignorance is *not* Bliss," because so many of them were admitted to hospitals and clinics with face-saving psychoneurotic reactions which were related to their inability to keep up with the others in training.

5. *The nature and strength of the ego:* The subject of ego strength is a large one, and time will not permit any great elaboration of it. The ego's function is to contain and compromise the opposing forces of the instinctual drives and their derivatives and those of the conscience in such a way as to permit the individual to function and deal successfully in the world of reality. Its initial nourishment comes from the love and interest of parents and from the early identifications with parents. Where infancy and childhood have been characterized by neglect, abuse, or disinterest of whatever cause, the individual is likely to be less capable of dealing with his own impulses, with his own conscience, and with reality in effective ways, and more likely to be tossed about by the ever-changing balance of these forces until a

¹Bauer, W. W., "The Changing Patterns of Motivation," in *Motivation in Health Education*, New York: Columbia University Press, 1948.

more restricted and more primitive type of adjustment is reached—like the 18-year old girl with the atrophied arm who appears to have renounced any kind of mature independent existence for the seemingly less troubled and stressful life of the dependent child.

From these general considerations I'd like to turn now to the more specific problem of motivation of a sick person to get well. All other things being equal, the desire to get well will be influenced by the intensity of suffering. Normally, we expect people to seek relief. How often do we see patients like the chronic alcoholics who refuse help and about whom we say, "They'll have to get worse before they can be helped," implying that when they suffer more they will be more willing to admit their difficulty and more willing to seek or at least be less resistive to accepting help? Unfortunately, all other things are not always equal. Some individuals seem to have not only a limitless capacity to suffer but a need for it. The picture of the masochistically oriented person who seems to enjoy suffering in a perverted way is no longer an unfamiliar one. Homeostasis or psychic balance is maintained through the suffering. This is what is referred to as the primary gain of illness.

This is in contrast to the secondary gain of illness which so often impairs motivation to get well. An example of this is the 21-year old boy, mentioned earlier, who refused many of the jobs offered him because they didn't pay enough. As long as he was disabled, his mother received a larger check. Compensation for illness has always carried with it the danger of impairing motivation to get well and has been a particular problem in industrial cases.

But there are other and perhaps more important secondary gains of illness which complicate the job of rehabilitation: the sympathy, care, dependence, and freedom from responsibility that go with illness. The value of these by-products of illness can be measured only by their importance to the specific individual. Freud² described a hypothetical man who lost both legs at the hips and who for twenty years had made an excellent living selling pencils from a comfortable little cart on an amusing and busy street corner. Suddenly, along came a surgeon who said to him, "My man, I can graft a new pair of legs on you and you can be as good as new." What would be the feelings and the conflicts of that legless man? Excitement, eagerness, and hope most certainly; but at the same time fear, some anger, misgivings, and a general feeling, "Why the devil won't they let me alone? I'm getting along all right; I am known here. People are kind and friendly; they look after me and protect me. If I get well, then I must stand on my two new legs without any crutches for my body or

for my spirit. No more special sympathy; no more alibis! I will have to compete in equal terms with other men—NO!"

Or consider the unequivocal negative reaction that one would get in offering the committed homosexual the possibility of a cure of his perversion—which is feared infinitely more than the deviation he has depended upon for his psychic equilibrium.

The range of motivation can vary from an unequivocal desire to be well to the exact opposite—the wish to die. Excluding from consideration those instances in which active steps to commit suicide are taken, I might quote an extreme case described by General Paul Hawley.³ It was of an Army doctor who had been in good health but who was found to have a hernia. He was operated upon without difficulty but went on to die of a paralyzed intestine for which no cause could be found. After he died, it was found that before he entered the hospital he had carefully laid out his full-dress uniform in which to be buried and had left instructions for his funeral.

When we consider the many factors which are involved in an individual's motivation, the wish (or the need) to be ill can be seen to have many possible origins. It may represent the assimilation of similar attitudes from parents. It may be associated with a conviction or recognition of a real inadequacy or limitation and an attempt to avoid any exposure to responsibility and the inevitable failure and blow to the ego that accompanies it. Consider how some mentally retarded or individuals with inadequate schizoid personalities must feel after having been laughed at since childhood when they have tried to be like others but have been made the butt of all the practical jokes that other children are so ingenious in devising.

In many individuals there is a feeling and a conviction of inadequacy that is without reality basis. Whether it stems from neglect, or exposure to the excessive and unrealistically high demands of parents that could not be met, or constant criticism or belittling, or suppression, the effect can be the same, a reluctance to try. At times an identical type of neurotic conviction of inadequacy may originate from feelings of sexual inadequacy that children are so prone to develop and that may persist in the unconscious for a lifetime. It may be related to anger or hatred that is expressed in this passive way. It can be designed unconsciously to punish the persons or the world who have been or are felt to be depriving

²Quoted by L. S. Kubie in chapter on "Myths and Resistances in Health Education" in *Motivation in Health Education*, New York: Columbia University Press, 1948.

³*American Journal of Psychiatry*, 104: 753, June, 1948.

or frightening. It may represent the yearning for love which was never experienced or it may represent the regressed result of sexual fears or feelings of inadequacy.

At times, we see patients who have been extremely industrious and hard-working, who after some stress or experience or accident, suddenly change and go to the other extreme. It is as if underneath, their drive was an effort to repress a striving for passivity that was present all the time and was looking for the appropriate and acceptable situation in which to express itself.

There are those patients who distrust their would-be helpers. Their distrust may have originated in repeated unnecessary disappointments in the past or in early misunderstandings of disappointments that couldn't be prevented. They would rather go without help than run the risk of expecting it and not getting it and then suffering the acute hurt. In this sense, the perpetuation of illness reveals its neurotic character in that it is geared toward attaining some pleasure in disguised or symbolic form.

L. S. Kubie in discussing the rehabilitation of veterans,⁴ a problem that is not dissimilar from the one we are concerned with, credits Harvey Cushing, the great neurosurgeon, with being the first to recognize that unconscious motivational forces play a determining role in the ability of veterans to accept their disabilities. In 1918 or 1919, he emphasized the fact that the most resigned and philosophical patients he had seen were those with a low transection of the spinal cord. It was as though the elimination of the influence of all of the subtly disturbing afferent impulses from the sacral area had removed from the patient a major source of constant discontent, of tension, and of energy and produced a happy acceptance of invalidism such as is seen in certain hysterical disorders. Kubie sees in this an experimental confirmation of the hypothesis that psychological tensions derived from unrecognized instinctual processes play a determining role in reactions to injury and disease.

All of these motivations toward ill health raises the question of what, if anything, is on the other side of the ledger. What hidden forces tend to restore individuals? Why does the neurotic ever renounce this pleasure of illness? It is not just the conscious wish to get well since some patients who can hardly wait to start treatment are the hardest to treat. There is, however, an awareness somewhere in the individual of what he is doing and the feelings of guilt that are derived from the hostile aggressive aspects of the continued illness and dependency press for relief and confession. At the same time the unconscious impulses themselves strive for expression and lend rein-

forcement to the compulsion to self-revelation.⁵ Contrary to what is commonly held, even many schizophrenics have insight into their illnesses and possess forces which strive toward recovery.

The same impairment of self-regard or self-esteem that may contribute to the illness acts as an opposite force for recovery, for the continued illness adds to the feeling of low regard. At times, the conscious, realistic disagreeableness of the illness and the deprivations it causes provide the positive motivation and the wish for help.

Before touching on possible approaches to improve motivation, a few words about the contribution of the patients' relatives and of the medical workers are in order. Their attitudes are not always as uniformly positive as we would like to believe.

Those who treat neurotic illnesses often have occasion to see how a patient's illness is an attempt to meet the unconscious need of someone else. This often is the case with alcoholics whose spouses, despite their protestations, derive some satisfaction from their mates' disorders. How often do we see the families of schizophrenics object when the patient begins to show signs of improvement? How commonly do husbands complain when, with psychiatric help, their wives relinquish the neurotic behavior which brought them to treatment in the first place, or vice versa?

As Kubie⁶ has pointed out, we are all human and subject to the very same weaknesses that we note in our patients. Consequently, we bring to our practice the same complexities and the same paradoxes and contradictions which trip up our patients. He points out that the idea of illness and the idea of sin are deeply and inextricably linked in human thought and feeling.

At times negative attitudes toward a patient may stem from realistic irritation but at other times they may arise from unconscious identification with the patient associated with a reaction formation against parallel wishes. The dependent and aggressive impulses that are inherent in the patient's clinging to illness creates anxiety in the health worker because of similar unconscious impulses in the worker that are unacceptable and need to be denied. It is as if having put himself in the position of the patient, he is unable to admit the wish for such an experience himself and he, therefore, over-reacts to it.

H. R. Blank⁷ comments on the inability of a

⁴Kubie, L. S. "Motivation and Rehabilitation," *Psychiatry* 8:69, 1945.

⁵H. Nunberg, "The Will to Recovery," *Int. J. of Psychoanalysis*, Vol. VII, 1926, p.64.

⁶Chapter on Myths and Resistances in Health Education, *Motivation in Health Education*. New York: Columbia University Press, 1948.

worker to think clearly and to focus on a client's problem when the worker over-identifies with the client as "crippled," "defective," or "castrated." The worker in such situations may show a high level of anxiety when he has to say "no" to the client. Such a worker may himself feel that any frustration or denial is a hostile act which it may not be in reality. He feels with the patient that he "deserves everything he asks for and needs to be protected from any burden or frustration, because he is helpless and crippled."

At times workers have an excessive need for approval from their clients and play the role of the omniscient all-giving mother. They may unwittingly prolong the clients' dependence to satisfy their own needs.

It is surprising and embarrassing to see how little attention has been paid to the problem of motivating the poorly motivated patient. The medical literature contains relatively little on the subject and yet it is one of the pressing problems of psychiatry. It is not uncommon to hear psychiatrists and their ancillary workers dismiss the problem of the patient who is in need of treatment but doesn't want it by saying that they'll be pleased to treat the patient when he *wants* help. Groups such as Alcoholics Anonymous have stepped into the vacuum created by this attitude (born out of lack of knowledge) with a moralistic, religious, and supportive approach which is as successful in some cases as a purely medical or scientific approach.

What are some other possible methods of approaching the problem? First, it is essential to eliminate the use of reality as a defense. The patient with the atrophied arm may attempt to attribute all of her difficulties to this disability. The realistic limitation must be acknowledged by the exaggerated importance attributed to it, it must be pointed out. Often non-physical reality problems such as finances or care of children are present and must be approached in a practical way, and in some instances this alone diminishes the patient's defensive behavior.

Second, it is necessary that the worker understand whatever need he may have to have the patient get well. While his emotional investment in the patient often helps, it may be the very thing that gets in the way and offers a vulnerable spot to the patient's perverse impulses.

Third, each patient must be evaluated individually since the dynamics in each are different. In some with a weak ego, strengthening it through support and opportunity to express anxieties must be the first goal. In others, growth is obtained through consistent confrontation with reality even if it is painful. This may involve explaining the nature of

the disability and pointing out to the patient in a sympathetic and understanding way the meaning of his behavior. It may get the patient angry, but it may disturb the equilibrium which has been maintained by illness sufficiently to further the wish for help. In this connection, it is important to bear in mind that while dependency often is an expression of hostility, it also generates hostility because of the limitations and restricted freedom of action that dependency carries with it. It is a good general rule that negative resentful feelings in the patient must be dealt with first, and it is well to remember the tendency of a person who is suffering from a disorder of organic or psychogenic origin to resent those who are better off than he. This was particularly apparent in the war when front line troops resented troops in rear areas of the combat zone, and when rear area troops resented those who were overseas but not in combat areas at all, and when men who were just overseas resented those who were still in the States.

Fourth, in some regrettable instances, only increased suffering will make the patient seek help in a genuine way, and it may be that in some instances discontinuing financial help, cruel as it may seem, may be the only means of starting a patient on the road to recovery. The Canadians have, to a much greater degree than the Americans, emphasized and offered treatment rather than compensation to disabled veterans, a practice with which we might well experiment.

Fifth, some will be helped by nothing short of intensive psychiatric treatment.

Sixth, sometimes it is possible to increase motivation in a patient by working with a neurotic relative who is unknowingly fostering the patient's difficulty. In this connection it is interesting to see the increased attention that is being given to the mothers of schizophrenics and the wives of alcoholics.

Seventh, wherever possible, efforts should be made to minimize the secondary gains of illness. In World War II and again in the Korean War, dramatic results were obtained in certain cases by removing patients from a hospital atmosphere as soon as possible and placing them in a less protective rehabilitation facility where an atmosphere of early return to duty was maintained.

Eighth, another lesson learned in the war was the force of group pressure on an individual. The greater use of group therapy for poorly motivated patients would appear to hold much promise. Patients will see in others what they find difficult to face in themselves, and the observations of the group will often have greater impact than those of the

⁷Blank, H.R., "Counter-transference Problems in the Professional Worker," *New Outlook for the Blind*, June 1954.

physician or health worker. Group therapy might be made a condition of relief payments in selected cases as has been done with considerable success with paroled prisoners. (I intend no insidious comparison.)

Ninth, the last possible approach I shall suggest is one of public education—that is, to reveal poor motivation as a problem and advertise it as one would the dangers of excessive drinking. At present there is a tendency to treat it with silk gloves, to avoid talking about it, to act as if it were not there, and to deal with such patients by sugar-coated words of helpfulness that never bring the problem out into the open lest feelings be hurt. I believe that one of the reasons that we do not see the gross hysterias we used to see years ago is that the public is wise to it now, and the woman who consistently develops headaches when she has to do something she doesn't want to, fools less people than formerly.

In other words, revealing the meaning of continued unnecessary disability and resorting to it will become more difficult. It is a public health problem for which one of the usual techniques (that of fear) cannot be used, but for which another, public edu-

cation, is eminently suited. The problem should not be approached by just advertising the joys and advantages of good health (for this makes no impression) but by revealing the negative, hostile, and anti-social elements of the acceptance of support when it isn't necessary. Give it the same reputation as the spitter in public places or the slacker in wartime. Publicize the extent of the problem (once it has been determined). Take the public into our confidence and let the children learn about it in school.

The problem still remains a difficult one. Despite all the efforts of the most competent individuals, there is still a large number of patients whom we are unable to help with our limited knowledge and with the attitude of our culture. As Kubie has said, "In science we may have to content ourselves with recognizing the existence of a problem for years before we find an answer to it." To recognize it, however, is the first step towards that solution.

Finally, we should remember that passivity is a defense that is provided by nature and while it is used unnecessarily by some, it may be that in some instances it is a life saving measure that should not be tampered with.



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INTEGRATIVE FIELD WORK EXPERIENCES FOR PRE-THERAPISTS

CARL HAVEN YOUNG, ED. D.*

The need for field work experiences in habilitation and rehabilitation, which will bring potential therapists closer to the realities of their chosen profession, is an accepted requisite for technical preparation. Since other educational institutions are undoubtedly faced with a comparable problem as is that of the department of physical education, University of California, Los Angeles, namely, the responsibility for the pre-clinical education in physical, occupational and corrective therapy and adapted physical education, it is believed that the attempt to embody these experiences through course offerings may be of benefit to those in similar situations. It is realized that various unique adaptations may be necessary to best adjust such offerings in keeping with the local arrangements. The course description presented is in the nature of a tentative prospectus.

It was early apparent that the complexity of the task made necessary the heterogeneous grouping of the several major students in these fields for purposes of expediency and economy. Likewise it was deemed advisable that such a course be sufficiently generalized in order to foster an appreciation of the interrelationships involved in the team approach; make known the unique contribution of each of the ancillary services and its place in the whole approach to the patient; take into consideration the fact that these students, while seniors, were not as yet qualified to treat patients; and that, therefore, such experiences should be limited to *orientation, observation, collateral reading, and lectures* presented by the cooperative staff of the hospital and coordinator of the university.

Through the cooperation of the Veterans Administration Center, the chiefs of Physical Medicine and Rehabilitation and staffs of the Wadsworth General Medical and Surgical Hospital and Brentwood Neuropsychiatric Hospital join forces with the Department of Physical Education at the university in offering their services. Working in conjunction with the university coordinator who is responsible for the class organization and supervision are the chiefs of corrective therapy and the clinical training supervisors who direct the clinical experiences and arrange for staff lectures. Although corrective therapists are

the responsible coordinators in this instance other specialists may well supervise in such functions when more readily available. In addition the chiefs of the various therapies, directors of other ancillary services as well as the physicians and surgeons contribute to the wealth of information which is made available.

Present plans call for the ultimate inclusion of other nearby hospitals, both public and private; clinics; and volunteer agencies, including the University Hospital Medical School for providing field work experiences or field trips. Such a plan offers broader opportunities for students to observe their specialty in various orbits, and may be of benefit in the recruitment of much needed technicians.

Two separate laboratory experiences are offered: the first semester course deals with clinical work in general hospital specialties; the second semester course covers neuropsychiatric needs.

A course syllabus is distributed to present the information which is covered in the entire course, including a portion of the items considered in the class period by the university coordinator. Considerable supplementary material and an extensive selected bibliography are included. Emphasis as to subject content presentation varies according to necessary applications in keeping with whichever course is being taken.

Introduction—Class Orientation

At the beginning of each semester the following aspects are considered during the first class periods in relation to the work of the facility where the clinical training is being taken. Particular stress is paid to these applications in relation to the patients' habilitation (or living with what they may have of physical capacity) and in respect to the rehabilitation needs.

1. Field work—the role in habilitation and rehabilitation.
2. The unique function in the educational preparation of pre-therapists applied to the general and neuropsychiatric patient.
3. Personal and professional values to the student.
4. Characteristics or criteria of field work experiences.
5. Nature and purposes of the course.
 - a. To foster an increasing interest in becoming better acquainted with the broad areas of habilitation and rehabilitation, their purposes and ap-

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plications in general medical and neuropsychiatric problems and programs.

b. To orient as to the interrelationship of services and the plan for the coordination of personnel and facilities.

c. To develop an insight as to the various types of conditions treated, the media and ancillary services utilized.

d. To promote a better understanding and knowledge of therapeutic procedures, effective techniques and professional ethics.

e. To increase personal preparation as to methods and skills in the application and selection of procedures, relationship with patient and medical personnel through clinical experiences under rigid supervision.

f. To inform and assist in orientation as to the respective relationships essential in the productive team concept of service.

g. To aid in the identification, selection, definition and structuring of experimental procedures and problems for personal research and investigation.

h. To promote a better understanding of and ability to utilize various methods and techniques through: lectures, observations, clinical opportunities, discussions and conferences, as well as reading assignments and written reports of experiences.

Basic requirements of the courses

As the major intent of these courses is to further implement the preparation of pre-therapy personnel for hospital or clinical service, definiteness as to requirements is imperative and in keeping with university regulations. Since a requisite of the professionally qualified technician is considered to be the ability to formulate and present concise information, particular attention is given to the mechanical aspects of: preparing reports of lectures and observations; searching for significant resources and abstracting these references; making condensations as to clinical experiences or research experimentation, and presenting results in the form of a final project report.

1. Prerequisites: include the sequence of prior courses required in each of the several majors; senior standing or consent of the university coordinator.
2. Wearing of uniform in accordance with hospital regulations.
3. Attendance at lectures, demonstrations, observations, class periods, clinical experiences and conferences with university coordinator, clinical training supervisor and others.
4. Class assignments will include: the reporting of

the above experiences in accordance with Table 1, "Criteria for the Utilization of Resources for Reports;" and Table 2, "Points for Discussion with Speakers by Class Members," which may be used for bringing out significant facts related to such reports. Abstracts will be prepared on materials related to the above experiences which are conducive to the increasing of knowledge in the field, from such references as: books, periodicals, theses, dissertations, etc., following the form shown in Table 3, "Guide for Evaluating Bibliographical References."

5. Such abstracts and reports will be turned in on 4" x 6" sheets of paper (preferably typed) with the subject of the reference in the top right hand corner, giving reference in proper form in accordance with instructions. These class assignments will be submitted in a manila card file and indexed by subject titles.

6. A project will be prepared at the end of the semester on any subject of the student's choice and related to his experiences in the course. This may be in the form of a case study of a particular condition, therapeutic procedures, techniques for administering a therapy, interrelationship of services, plan for coordination of ancillary services, evaluative criteria, experimental studies, or other subjects of a similar nature. Submit in stiff black covered folders.

7. A personal evaluation with reference to the field work experience in relation to the hospital, academic preparation in the University, and suggestions for improvement of the course will be required at the end of the semester.

8. Conferences will be held with the student, hospital clinical training supervisor, and university coordinator for the purpose of ascertaining progress toward purposed goal.

9. Professional ethics will be observed at all times and where there may be doubt as to the proper procedure, guidance and counsel should be sought.

Coordinated plan of relationship

The following prospectus which is built around present available facilities for field experiences seeks to plan for the future and the use of other expanding opportunities. As these develop, changes will necessarily take place in the relationships which are presented, in keeping with new situations.

1. Procedural pattern and assignment.
 - a. The instruction and supervision of students enrolled for Field Work in Habilitation and Rehabilitation is the shared joint responsibility of representatives of the hospitals, schools, and other agencies conducting these experiences and the

Program or Occasion **Where?**
 1. Subject of conference, observation or presentation.
 2. Where held and for what purpose.

Speaker, Moderator—Demonstration or Observation **Who?**
 1. Person or persons as resources
 2. Connections and directed to whom

Information Derived **What?**
 1. Major premises clarified
 2. Applicability and directed to what purpose

Methods and Techniques Utilized **How?**
 1. Physical environment and facilities
 2. Diagnosing and follow-up procedures
 3. Forms of leadership

Applicable to Specific Situations **When?**
 1. Evaluative criteria for determining
 2. Experience and technical preparation necessary

Research Ideas Promulgated **Why?**
 1. Statement concerning the purpose, implications, suitability, fundamental methods and techniques, values to be derived and recommended references.
 2. Materials obtained and suggestions as to other resources and persons to contact in following through with the investigation.

Points to Keep in Mind
 1. Method is a *way* of doing a thing, theory is the *why* it is done, techniques are the tools and *how* to accomplish, and activity or program is the *what* or means for reaching the goal proposed.
 2. Remember that no program sold itself. Leaders sell programs and make them meaningful.

Table 1. Criteria for the Utilization of Resources for Reports.

coordinator from the Department of Physical Education of the University of California, Los Angeles.

b. The university coordinator is responsible for the orientation, assignment to the respective facility, conduct and recording of grades, working in close cooperation with the personnel offering the field work experience.

c. A regular class period is conducted weekly by the university coordinator with all members of the group who are working in 190A, the first semester course, with a similar class period for those in 190B, the second semester course. Problems concerning procedures, activities, general practices, techniques and their application are discussed. Assignments and other requirements such as uniforms, professional ethics, and responsibilities are clarified.

d. Students are assigned to approximately five hours of practical experience per week in addition to the class period, and upon satisfactory completion of the course in either 190A or 190B receive three units from the university. Either course may be selected toward meeting the requirement, while the other is accepted for additional elective credit.

2. Method of Operation.

a. The practical aspects of the program for field work in the Veterans Administration Center is conducted under the direction of the Chiefs of Physical Medicine and Rehabilitation at the Wadsworth General Hospital and the Brentwood Neuropsychiatric hospital.

b. A comprehensive program of activities is arranged whereby students are provided a variety of opportunities to receive as many different types of experiences as possible and practical in keeping with their present preparation and qualifications.

c. Students are classified as volunteer workers and are directly responsible to the respective chiefs, corrective therapy; who in turn delegate immediate supervision to the clinical training supervisors, who may assign their direct experiences to various corrective therapists.

d. Plans are mutually prepared and organized

Clarify as to: *where* the specialization is practiced; *who* is best qualified to conduct the work; *what* the field covers which is distinctive from other therapies; *basic* educational preparation necessary; *when* such services are most applicable; *how* best utilized for good results; and *why* there is need for such therapy.

Seek to discover possible areas of research where further investigation is needed, and ways whereby greater recognition, more adequate compensation and higher standards may be secured for the professional person in this field of specialization.

Check to ascertain if all necessary material for the completing of the "Criteria for the Utilization of Resources for Reports" has been obtained. If important and necessary endeavor to obtain this information from the resource person.

Other pertinent ideas should be brought out through adroit and significant questioning which will supply the desired answers. Professional ethics should be observed in seeking such replies from your guest and a sincere expression of appreciation for his investment of time and energy is always in order.

Table 2. Points for discussion with speakers by class members.

with the university coordinator in accordance with university and hospital requirements and regulations.

Nature of rehabilitation field work experiences

The program and extent of professional experiences are planned in terms of the background and needs of the students, offering opportunities for: guided participation, the implementation of theoretical knowledge, a chance to observe and gain understanding in the technical skills and techniques in specific applications, a means for the raising of questions as to problems and their solution, and a collating of information and personal evaluation of ability and needs.

1. Orientation includes a coverage of the following aspects:

- a. An explanation of the important feature of the course previously described in this outline by the university coordinator.
- b. Conducted tours of physical facilities by the clinical training supervisors; illustrated talks by representatives of affiliated hospital services; observation of surgery and autopsies; use of films, slides, recordings and other training aids; the use of library references and conferences as a means of implementing knowledge; all of which are either preliminary to or in conjunction with actual clinical experience.
- c. The areas included in this orientation are as follows: nursing service, medical psychology, special services, vocational counseling service, physical therapy, occupational therapy, corrective therapy, recreational therapy, educational therapy, manual arts therapy, domiciliary care, gerontology, blind rehabilitation, surgery and autopsies, brace facilities, and other experiences.

2. Clinical opportunities for experience are offered as follows:

- a. The Veterans Administration Center, through the courtesy of the corrective therapists under the chiefs, physical medicine and rehabilitation in the respective hospitals and chiefs of corrective therapy, together with other therapies and ancillary services personnel, provides the instruction and supervision for the students. The staff, also, serves as resource persons for ensuring an understanding of: types of conditions; various techniques and media; follow through of physician's recommendations; assistance in patient adjustment to conditions they are required to face as: self care, insight and motivation leading toward re-socialization and improvement of occupational skills.

b. Clinical applications are provided and available in the Wadsworth General Medical and Service Hospital for 190A students in the corrective therapy general area, roof clinic, convalescent annex, and the domiciliary unit. At the Neuropsychiatric Hospital the 190B students gain in-

The following may be used as a guide when reading, digesting, abstracting or annotating articles or references. It should be understood that this is not a complete analysis suitable for a collateral reading report but only an abstract which may be helpful in locating the significant aspects of the references.

1. *A statement regarding the purpose of the article or book.* What it deals with or considers (Usually found in the introductory paragraph.)
2. *What important points or interesting materials were emphasized?*
3. *Were methods for solving specific problems disclosed? If so, what?* (Example: Literature pertaining to anger was reviewed and ways of overcoming these difficulties were suggested.)
4. *Author's hypothesis or conclusion.* (Cites references to support his contentions. Offers criticisms.)
5. *Personal evaluation.* Does it have apparent validity? Is it of particular value to you? If so, in what way? The reference may have special application to some particular study which you are making. If so, show how. You may agree or not with the author, but do not set yourself up as an authority unless you are able to substantiate your opinion.

Table 3. Guide for evaluating bibliographical references.

formation through experiences selected from clinics dealing with the regressed, interim and chronically ill patients.

3. Lecture presentations are arranged by the clinical training supervisor and university coordinator, and conducted as follows:

- a. At Wadsworth General and Surgical Hospital the ensuing aspects are included: Civil Service Classification; Nursing and Ward Service; Medical Psychology; Medical Social Service; Special Services; Physical Medicine and Rehabilitation; Vocational Counseling Service; Arthritis Service; Orthopedic Service; Neurological Service; Neurosurgery; and others.
- b. At the Brentwood Neuropsychiatric Hospital such lectures may cover the following areas: Mental Illnesses and Typical Behavior Patterns; The Role of Manual Arts Therapy; The Role of Educational Therapy; the Values of Physical Activities in a Neuropsychiatric Hospital; The Role

Please check your appraisal of the student in those experiences you have observed as to the following factors considered to be significant. Judge effectiveness as "excellent," "satisfactory" or "poor."

Name Date

Facility or Situation Evaluator and specialization

Personal appearance and grooming habits. Check following:

Attractive ☐ Good Posture ☐ Poor Posture ☐
Always Neat ☐ Usually Neat ☐ Rarely Neat ☐

Attitude, rapport, adjustment toward:

Patient ☐ Therapist ☐ Medical Personnel ☐ Coordinator ☐
Indifferent ☐ Interested ☐ Enthusiastic ☐ Casual ☐

Behavior toward others in his relationships. Check following:

Friendly ☐ Cheerful ☐ Tactful ☐ Considerate ☐
Reserved ☐ Familiar ☐ Overly confident ☐ Tactless ☐

Professional approach and understanding. Check following:

Exceptionally fine ☐ Reasonably fair ☐ Notably poor ☐

Personality characteristics observed. Check following:

Well poised ☐ Sincere ☐ Agreeable ☐ Reliable ☐
Industrious ☐ Shy ☐ Talkative ☐ Retiring ☐
Self-conscious ☐ Irritable ☐ Lazy ☐ Aggressive ☐
Conscientious ☐ Resentful ☐ Immature ☐

Knowledge of therapeutic procedures and techniques observed in:

Clinics ☐ Lectures ☐ Discussions ☐ Demonstrations ☐

Professional Ethics — (Judge as "E", "S" or "P")

Demonstrate effectiveness in seeking information as to following:

(Judge as "E", "S" or "P")

Various types of conditions treated, amount of activity and by whom —.

Respective media and ancillary services utilized in specific cases —.

Significant problems confronting therapist and PM&R personnel —.

Techniques for following through physician's recommendations and procedures for referring information back to him —.

Interrelationship of services and plan for coordination —.

Understanding of various forms and material used —.

Means for evaluating the results of the respective treatment —.

Seeks to discover experimental procedures being considered or tried —.

Your opinion of the student as a potential therapist —.

Would you desire to have this student as a colleague? Yes ☐ No ☐

Reason for this opinion

(Signature) Clinical Supervisor

Coordinator

Table 4. Guidance Evaluation of Student

of Physical Therapy; The Role of Occupational Therapy; Psychiatric Terminology; Discussions of Prescriptions and Progress Reports; Body Mechanics in a Hospital Situation; the Neurological Patient; The Approach of Physiatry to Rehabilitation; and others.

c. During the weekly class period the discussion is carried on by the university coordinator and often the clinical training supervisor, jointly, in the form of a forum, seeking to relate the students' observations to their goals for preparation. Further clarification of course requirements are considered as a means of improving professional standards.

4. Other activities offer information for the student, such as:

a. Various films are available such as *Activity for Schizophrenia*; *R. X. Attitudes*; *The Neuropsychiatric Patient*; *Seizures*; *Feeling of Hostility* (two reels); *Feeling of Depression*; *Angry Boy* and *Overdependency*.

b. In-service training lectures, films and training aids, medical matters and procedures, employee health and welfare problems, need for support of financial or legislative bills, and problems of general concern.

c. Lectures in the student nursing program for affiliate nurses are available for the student.

d. Attendance at therapeutic boards offer many opportunities.

e. Demonstrations of various non-physical medicine and rehabilitation therapies, as: EST, CO2, and Insulin.

f. Use of hospital library facilities and university coordinator's file of references offer a resource of information in all phases of the respective program.

g. Discussions and evaluations of activities and students' progress.

5. Visitations to other medical facilities and meetings as:

a. Hospitals and clinics nearby including: Sepulveda Veterans Hospital Center; University of California Medical School; Billig Clinic; Los Angeles Orthopedic Hospital; Children's Hospital; California Rehabilitation Center; and others available.

b. National Rehabilitation Association; The Association for Physical and Mental Rehabilitation; Adapted Physical Education Institutes and Conferences, etc.

Evaluative Procedures

An important aspect in the counseling of the students includes the use of the "Guidance Evaluation

The following questions are submitted for your evaluation for the purpose of assisting the university and hospital training center in the development of the Field Work Experience in Rehabilitation. Such an appraisal can only be meaningful if you give your frank and considered opinion. Use the back of the page for additional remarks.

With reference to the hospital training center

1. Did you enjoy your work experience and why?
2. Did you feel it was profitable, why or why not?
3. Did the amount and type of supervision seem inadequate? Explain.
4. What are the good features and why?
5. What suggestions have you for improvement?
6. Did you make the most of your opportunities?
7. Would you have benefited more with additional schooling?

With reference to university preparation

1. Indicate how adequate you found your academic preparation in relation to this area of training. Be specific as to subjects.
2. Indicate any other outstanding or weak points of your training in the University or at the Hospital.

Table 5. Form for student evaluation of Pre-therapy orientation.

of Student" (Table 4) an appraisal which is made by the clinician in each separate clinic following the student's completion of each clinical assignment. Information as to his progress in the course is conveyed to the student in the middle of the semester in order that he may take necessary steps for improvement.

The class assignments which are submitted weekly to the university coordinator are graded and returned at the following class session. At the end of the semester all the different phases including the: clinical aspects, class assignments, and final project are considered, and a final evaluation determined, jointly, by the university coordinator and clinical training supervisor.

Members of the class are, likewise, asked to submit their "Student Evaluation of Pre-therapy Orientation," as shown in Table 5. Through these media many helpful suggestions have been incorporated in the course revisions.

Cont'd on Page 20

HUMAN RELATIONS IN CORRECTIVE THERAPY*

RAYMOND B. HEASLET**

We may well question whether we need a sermon on human relations in corrective therapy. I admit that corrective therapists succeed better in human relations than other comparable groups. I strongly suspect that good human relations were a very important factor in the early development of corrective therapy as a profession. Undoubtedly, those of you who were responsible for the acceptance your profession has attained thus far were very adept in many, if not most, of the principles of good human relations. However, if I may be permitted a personal observation at this point (and you may well question it, as I have not documented any evidence) it is this: *we are in danger of becoming less vigorous and proficient in the art, or science if you prefer, of successfully relating to others both within and without our organization.*

Corrective therapists work almost exclusively with people, with patients, and with other members of the treatment team. Since this is true, shouldn't we be more than just good in the art of human relations? Shouldn't we be expert? Know and practice (and I emphasize practice) all the accepted principles that have been developed? Be thoroughly familiar with all the concepts and attitudes having a bearing on ways of getting along with people?

Shouldn't we go further, and do some experimental studies and research ourselves? And let others come to us for help in solving their problems in human relations instead of our having to go to them?

The art of human relations is not new. It is the *science* of human relations that is of somewhat recent origin. For hundreds of years men have worked at getting along together, and they at least succeeded well enough so that little thought was given to any scientific approach. The Industrial Revolution has been blamed for the lessening of our ability to get along well together. This movement replaced the tools of the independent workman with machines and transformed craftsmen, who had been their own bosses, into hired hands subject to the orders of foremen or managers. Men began to feel swallowed by a

vast impersonal machine, which rubbed away their self-respect and their identities. It has been said that it was the anger against this betrayal of the human spirit, that caused millions to listen to the false promises of Marx's counter-revolution, which as we have seen, only led to greater loss of self-respect and finally, to a form of slavery.

Since it was impractical to turn back the clock, and wipe out the Industrial Revolution, a few pioneers set about promoting a second Industrial Revolution—Human Relations in Industry. Its purpose is to give the American worker a sense of usefulness and importance. Isn't that one of our purposes in providing corrective therapy for our patients? To give them a sense of usefulness and importance? This principle was expounded and put into practice in the 1920's by Elton Mayo, sometimes called the father of this second Industrial Revolution. A few years later a startling thing happened which really woke industry up to the need for vigorous attention to the *science* of human relations. The Western Electric Company tried an experiment on the effects of lighting on the worker and his output. They properly set up an experimental and a control group in two special work rooms. Variable lighting was used in the experimental room and the lighting in the control room remained as before. The results are probably quite familiar as they have been published widely—production shot up in both rooms! This was totally unexpected and could be explained only on the basis that both groups of workers had been singled out for special attention, and their need for recognition was so great that increased production completely dominated any effects of lighting. (We know that lighting ordinarily does affect production).

So here we have our first principle, historically speaking, of the *science* of human relations: *Recognize our fellow man as an individual.* Corrective therapy, since its inception, has been high in recognition of this principle. We must not relax this ideal but should strive to improve its utilization as an effective aid to therapy.

Should we scoff at the idea of a science of human relations? Does a science require a laboratory building with test tubes and Ph.D.'s or M.D.'s in white coats peering into microscopes? Current thought considers science as encompassing a broader field. Emphasis is on experimental attitudes utilizing the three major

*Condensed from a paper read at the Tenth Scientific and Clinical Conference, Association for Physical and Mental Rehabilitation, Augusta, Ga., June 1956.

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steps of the scientific method: First, observe the situation (any situation) and gather available facts. Second, arrive at a theory to explain the facts. Third, test the theory by an experiment which can be repeated by any other qualified observer.

Another early experiment that has been repeated by many qualified observers is the one seeking the main cause of discharge among employees. Every report I have read shows the same leading cause, though percentages vary from 65% to 80%. The main reason for discharging employees is *not* lack of skill for the job, lack of training or experience; it is *not* for dishonesty, lying, stealing, cheating; it is *not* because workers are too slow on the job, or in learning new skills necessary to keep abreast of progress. No! The main reason is that "they couldn't get along with other people." Another study was made on why employees failed to get promotions. "Failure to get along with others" was the reason given in 76% of the cases.

Experimental proof of some of the principles of human relations would really not have been necessary if we had only accepted them. They were spoken by philosophers hundreds of years ago. Over 2,000 years ago Sophocles said, "Fortune is not on the side of the fainthearted." How often we see the "bold stroke" paying off, in sports or in business! An old legend tells one version of the story of the Israelites and the Red Sea. Encouraged by Moses to believe the waters would part to let them through, the Israelites arrived on the shore to find the sea impassable. It was not, the story goes, until the first man waded in, that the waters drew back. Fear is not all bad, however. We should not try to deny its existence. It may even be put to advantage.

Much has been said in recent years about the "team approach." In the treatment and rehabilitation of patients, top management has been very insistent in this. So we have complied. And some of us have been shocked to have visiting supervisors say, "You don't have a team! You only have fifteen different individuals meeting together and working separately." Some of us have been puzzled. What is a team? Why isn't ours a team? An incident at our hospital recently may shed some light on the answer. All members of our team had agreed on a certain action, save one. Now, a minority difference of opinion certainly does not violate the team concept. Such differences should be expressed at length and heard and considered. But this employee went further. He became so unpleasant and emotionally involved that other members of the team were embarrassed. He even went outside the team with ridicule and attempted to gain support for his position from those less familiar with the facts, on the grounds of a moral responsibility to fight for

his convictions. Now, what was wrong with that position? Simply this: It was not a moral question that was being decided. It was not a religious question that was being decided. It was the question of the best treatment and rehabilitative measures to be adopted for a particular patient. And one member succeeded in wrecking the efforts of the entire team.

One representative of top management¹ has defined the team as "a field of activity in which the role of an individual is determined by the aims, successes and failures of other members rather than by the goals, knowledge or skills inherent in the individual himself. *No matter how skilled an individual may be, he can be effective only to the extent that others are willing to facilitate the use of his skill!*" He adds, "sometimes individual prerogatives must be yielded if there is integration of the group to a common purpose. This may be frightening to those who fear loss of their individuality and it is such fear that sometimes creates group tension, rivalry for status and inter-personal dislikes."

If we can accept the above definition of a team, then we can, at least in some instances, understand why our top management supervisors have scoffed at our perfunctory attempts at establishing a treatment team.

The same line of thinking is reflected in an outline of a course of study in Human Relations in Work Groups.² The very first basic principle listed is as follows: "The productivity or success of a work unit is measured by the degree of *co o p e r a t i o n* existing among all members of the group." Before nodding our heads in harmonious agreement to this principle, let us examine it more closely and see if we can do so without conflict. Perhaps to really accept this principle we may have to give up some pre-conceived ideas, and this may not be easy.

How many of us still hold to the quaint naive idea that the way to measure success of a work unit is to total up the amount of work that was done? For instance, let's use a simple example. Six men are picking cotton in a field. If I were to judge the success of these men, it would be on the basis of how many pounds of cotton they picked. I dare say most of you would do the same. Cooperation would be fine. Yes, they could probably do better working together, but primarily wouldn't the foreman be interested in the amount of work done?

The basic principle said, "The productivity or success of a work unit is measured by the degree of co-

¹Tompkins, Harvey J., "The Strength of the Group," *Tech. Bull.* 10-47, Veterans Administration, Oct., 1953.

²Beecher, W.; Bennett, W. D. and Zappolo, F., "Case Dynamics," mimeographed, Brooklyn: Beecher Remedial Center, 1952.

operation existing among all members of the group." It didn't say "*partially*" measured, or "the degree of cooperation existing among *most* of the members of the group." It said "measured" and it said "the degree of cooperation existing among *all* of the members of the group."

Those of us who understand cotton picking know that the contrariness of any one or more than one of the six men need not necessarily interfere with the productivity of the others. Any one of them could be quarrelsome, late to work, lazy, dishonest, or what-not. It *might* interfere with the others but *need* not do so. Generally in picking cotton, each man does his own work and does not have to depend on others for anything.

So either the basic principle is untenable or our use of an illustration is in error. Let's take the same six men and give them another simple task of carrying a heavy log, weighing say, 1000 pounds, assuming there is no equipment or machinery to do the job. Clearly no one or two of the men could carry such a heavy log by hand. Every man would have to lift his part and do it at the same time as the others. Here we have a simple but real team. With this team we can agree that the productivity or success of the work unit can be measured by the degree of cooperation existing among all the members.

If we consider the etymology of the word "team" we would not foolishly think we had a team when we put six men in a field, each individually assigned to picking cotton or by merely meeting together in a room and talking about a patient, but each going his own way in treatment procedures regardless of the opinions of others. Or verbally agreeing, for the sake of harmony, but with mental reservations, thinking that "by the eternal, we know our job, and that we could do it better too, if others would mind their own business and let us alone."

The word "team" is a good old Anglo-Saxon term. Anciently it applied to two or more beasts of burden harnessed or yoked together and working at the same task, a task which none could do working alone. My grandfather would have understood. If he had harnessed two, three, or five horses (any number) to different vehicles, plows or what-not, even if they were all in the same area or field, he would never have made the mistake of calling them a "team." Grandpa knew another thing: He knew that in a job requiring a team of, say, two horses, the total work possible by these two horses cooperating as a team would be exactly twice the strength of the weaker horse—not one bit more! And that only—mind you—if they cooperate perfectly. If the stronger horse tries to show up the weaker—or if the weaker tries to undermine the stronger, the total work done will be even less!

Sarcasm is in poor taste (and rightly so) but perhaps we can tolerate just a little bit: The corrective therapist who can do the complete job of treatment alone, does not need to belong to a team. The rest of us do!

Perhaps we won't have so much trouble accepting the other basic principles listed. Failure in a work group results from either (a) lack of knowledge or skill in how to function, or (b) unwillingness (usually unconscious) on the part of any one or more of the individuals to contribute to the total work requirements. Such failures as are due to lack of knowledge or skill can usually be remedied by specific factual and skill instruction. Most failures, however, stem from problems in human relationships arising from secret or open unwillingness to cooperate.

The primary functional responsibility of supervisors is to produce team cooperation where each individual works to accomplish the total job. Supervisors do this by (a) understanding and removing hostile activities and attitudes restricting production, and by (b) teaching those who do not know the job and seeing that their work meets the standard required.

The hidden and open hostilities and jealousies existing in a work unit usually arise from a contest to determine which individual can surpass or dominate another. Such a conflict ties up productive energy and cuts down production by that amount. Almost all problem situations in human relations are the result of jealously competing individuals. Hidden somewhere in the conflict is the attitude of "Big Me and Little You." In each conflict situation the objective of dominating the other is normally concealed behind a "good reason."

In each work unit a group "climate" or opinion exists which either fosters or discourages cooperation. In a climate of cooperation, mutual trust and helpfulness flourish and grow. One worker does not have to struggle against another and his energies are free to devote to production. He does not have to be watchful for attack from a fellow worker or supervisor. Each supports the other's efforts. Work seems easier since none is haunted by the fear of failure or ridicule. One does not profit at the expense of the other. Individual contribution to the total group is recognized by the supervisor and workers alike. In a climate of excessive jealousy each must fight against his fellow workers and against his supervisor. He can depend on one one for help or tolerance unless he can enlist support of a few around him. If he contributes on the job or gains recognition, others begin jealous attacks on him. If he lags behind, others are jealous of his ease. He has little thought and energy free for productive effort on the job.

Due to the authority lodged in the supervisor, he primarily sets the climate of opinion, whether he recognizes it or not. No one is wholly free of the attitude of "Big Me, Little You," and each person needs to guard continually against aggressive "Big Me" traits. Each supervisor infects his unit to the degree that he himself is a victim of "Big Me, Little You."

The successful supervisor places cooperation in the work unit before personal recognition. He recognizes that the total requirement of the job is the boss of the unit. He recognizes that his own behavior is the master key to the situation and that his own drive for production regardless of means is actually a self-centered desire of seeking recognition for himself at the expense of the group. He assists the worker in understanding his responsibility to the job and to the group. The successful supervisor supports attitudes of cooperation and teamwork through which men feel security and satisfaction. He denies all profit to those who disturb teamwork by jealousy. He recognizes

that his responsibility to the job and to the entire group may conflict with the special interest of the individual and insures that the group and job responsibility predominates.

If some of these basic principles of human relations sound strange, should we not, in deference to the authoritative positions of the authors, subject them to more careful study and the application of concrete examples, much as we did for their first basic principle on how to measure success in a work unit?

If others of these basic principles sound somewhat familiar we should not be too surprised. They are merely re-statements, in many words, of the one basic principle stated two thousand years ago and now known as the Golden Rule.

CONFERENCE REPORT

PRE-THERAPISTS—Cont'd from Page 16

Course Appraisal

Following the first complete year under the present curriculum a re-evaluation of the program and teaching syllabus was made. A progress report was prepared by the coordinator and presented for consideration: first, to the members of the Rehabilitation Unit of the Department of Physical Education; and second, to those concerned from both Veterans Hospitals, the University Medical School representative, chairman of the Department of Physical Education, the clinical training supervisor, and program coordinator.

Many worthwhile suggestions were made for further implementation, including the seeking of expansion to include similar experiences in conjunction with the University Hospital School, with the addition in the syllabus of certification requirements for each therapy and other such information.

It was mutually agreed that the operational plan of integrating various pre-clinical therapy students for field work experiences is a feasible procedure which has met with considerable success. While it is recognized that this program has proceeded in an exploratory manner and that there are undoubtedly better ways which have not as yet been included, it is recommended that serious consideration be given to the adoption of such a plan by other institutions wherever it may be feasible.

(EDITOR'S NOTE: Summaries of papers presented at the Tri-State Physical Fitness Conference held at New York University on February 17, 1956 appeared in this *Journal*, 10:2:53-54, March-April, 1956. A summary of the group discussions and the speakers' comments during these discussions has been prepared by Dr. Raymond A. Weiss, conference coordinator. Speakers taking part in the program included Dr. Peter Karpovich, Springfield College; Dr. Joseph B. Wolfe, Valley Forge (Pa.) Heart Institute; Dr. Creighton Hale, research director, Little League Baseball; Dr. Bernard E. Hughes, State Charities Aid Association, New York, and Drs. Roscoe C. Brown and Charles A. Bucher, New York University. Nearly 500 persons including school administrators and teachers of health, physical education and recreation attended the conference and took part in the group discussions summarized here.)

The speakers' comments and the group discussions centered mainly around five questions:

1. What is the value of physical fitness?
2. How much physical fitness do the youth of America need?
3. What programs are needed to develop physical fitness?
4. How should physical fitness programs be organized and administered?
5. How can we evaluate physical fitness?

A summary of points made during the conference are presented separately for the speakers and for the group discussions under each of the above five questions.

What is the Value of Physical Fitness?

SPEAKERS

Physical activity enriches life.

Physical fitness is needed to fully enjoy sports with fun as a goal. If not physically fit, a person's interest in physical activity may wane and he is not likely to gain that exhilarating feeling that can come from exercise.

Everyone agrees that the person who is physically active and who has physical fitness enjoys a healthy mental outlook and a general feeling of bodily well being.

Physical activity relieves emotional strain under which we live and relieves the pressure of our highly productive lives.

A person needs physical fitness to safely participate in physical activity. When fit, physical activity provides pleasure and enjoyment; but if unfit, a person may find activity disagreeable and uncomfortable.

Physical fitness is needed to perform the daily occupational, home and recreation activities without undue muscular soreness, strain, fatigue or exhaustion.

Fitness is needed to meet emergencies involving severe muscular exertion.

The modern way of life eliminates some life activities (hunting, making shelter) that develop character and courage. Strenuous physical activities may provide a substitute for some of these developmental life activities.

Physical fitness is one type of fitness for life, and it is fitness for life which is the concern of education.

During illness, inactivity retards recovery whereas exercise speeds up convalescence.

There is some evidence that people on physically active jobs have fewer coronaries than those with sedentary jobs.

Although exercise is not the answer to reducing, there is some evidence that exercise goes a long way toward weight control.

There is evidence that exercise gives relief from dysmenorrhea.

There is some evidence that physical activity helps in adjustment of mental patients, but it is not shown if this improvement results from changes in physical fitness or merely from opportunity to express themselves through activity.

GROUP DISCUSSIONS

All groups tend to agree with the values put forth by the speakers during the morning session. All levels, elementary through college, particularly emphasize that physical fitness contributes to a feeling of general well being. All levels also believe that developing physical fitness is an important aspect of the general goals of education.

All levels also believe that fitness gives freedom from physical strain which in turn permits a better adjustment to the school program.

The elementary groups emphasize that it is im-

portant for children to develop an attitude early in life about appreciating their bodies and how to use them.

The junior high school groups emphasize their concern about the time of puberty. They indicate that physical fitness is important to the child who becomes very much aware of bodily function at that time.

The college women indicate that physical fitness is critical at that level because of child bearing.

How Much Physical Fitness do the Youth of America Need?

SPEAKERS

Various agencies in the country have standards: AAHPER and N. Y. State Education Department endorse the pre-induction physical fitness standards of the U. S. Department of Defense; Oregon recommends the Rogers PFI Norms; the Kraus-Weber Test has been recommended as a national norm; the YWCA has national norms; and the Boys Clubs have national norms.

Whereas standards like these have been proposed, it has never been established whether these standards actually are placed at the level which is desirable for our youth. The reason probably is that we haven't been able to decide just how much fitness our youth need.

Whereas we can agree that we need enough fitness to conduct the day's activities without undue fatigue, strain or exhaustion (and possibly to meet emergencies involving physical activity), we cannot decide what level of physical fitness this is.

GROUP DISCUSSIONS

All groups make general statements about the amount of fitness needed, such as enough to insure optimum growth, enough to contribute to good living enjoyment, enough for daily living requirements, enough to handle the body effectively, etc. However, all these suggestions do not reveal how much is enough. Some groups recognize this and recommend research to learn just how much fitness is needed in each case.

Some of the groups disagree in their recommendations. For example, one group suggested that the best fitness is the most, while another group is not sure this is so.

The secondary girls believe it is important for girls to have as much physical fitness as boys, whereas the college women state that girls do not need the same level of physical fitness as boys. Most of the groups agree that there is a definite need for standards but do not make specific recommendations. However, the senior high school boys' group recommends that we use existing national standards (it is probably referring to the statement of speakers that stan-

dards do exist for some of the tests being used in the field).

What Programs Are Needed To Develop Physical Fitness?

SPEAKERS

IN PHYSICAL EDUCATION. There is evidence that special conditioning type exercises like situps, running, and weight training increase fitness more effectively than a sports type program.

There is evidence that the best way to develop strength in certain muscle groups is to exercise those muscles with special exercises.

Differences in value of activities to increase physical fitness are most notable when used on subjects who are low in fitness. In at least one study, where the subjects were in pretty good condition at the start, sports type activities were just as effective as conditioning type activities in maintaining physical fitness.

Whereas some types of activities seem to raise physical fitness more rapidly than others, it appears that if the program is carried out continuously, just about any physical activity will make some contribution to increased physical fitness. The important thing seems to be to have the program well planned and continuous.

IN RECREATION. Recreation programs should teach sports skills starting in the elementary grades so that youngsters will be motivated to participate in activity programs. People tend to continue to do the things they do well.

Team sports should be included in the recreation program not only for their fitness value but also because they stimulate team spirit, sportsmanship, courage, persistency.

Individual sports also should be included in the recreation program (archery, bowling, golf, hiking) because they can be carried on into and past middle age.

IN HEALTH EDUCATION. People need to be taught basic facts about physical fitness; this is necessary if fitness is to be achieved. People need to form attitudes about physical fitness. Education can be a tool to do all this, and health education is one way to provide this education.

Health education can help to shape attitude about the need for physical fitness. Health education can help build public opinion to support needed resources for developing physical fitness.

Health education for physical fitness can be applied in three levels: in the school, at home, and in the community. The health educator can shape attitude in the school by what he says and by how he behaves.

Also, the physical environment and facilities affect attitude.

In the home, parents must act consistently with school teachings. They set an example for children to follow. The food they provide, the way they spend money, the way they feel and act toward others all affect attitude toward physical fitness.

In the community, practices in voluntary health programs and the services and advice of doctors, nurses, and other health service personnel all help to shape attitude about physical fitness.

GROUP DISCUSSIONS

More than anything else, the groups emphasize activities which employ the fundamentals of running, jumping, climbing, throwing, kicking, and the like.

The elementary group shies away from formal activities in favor of the less formal rhythmic, beginning sports and modified sports.

Most groups stress that the programs should have variety. The groups recognize that youngsters can exert themselves physically through many different kinds of activities and not simply through one or two certain types.

Sports activities are mentioned generously in all the groups as means of developing physical fitness. However, the junior high boys' group believes that special physical fitness exercises are needed. The senior high boys' group recommend an intramural program as a means of developing physical fitness.

It is interesting that the college men's group recommended that the program be designed for other objectives but point out that physical fitness will naturally be a byproduct of the program.

The health education groups emphasize that health education programs should stress the importance of recreation and physical education. These health programs are needed to develop wholesome attitudes toward physical fitness.

How Should Physical Fitness Programs Be Organized and Administered?

SPEAKERS

IN PHYSICAL EDUCATION. There is evidence that a daily exercise requirement is needed for effective development of physical fitness. However, at least one study shows that as little as 40 minutes, twice a week for 3 or 4 months will bring about significant changes in fitness test results.

The New York State Fitness Conference held in 1951 recommended daily activity in physical education programs amounting to 150 minutes weekly for the elementary schools and 225 minutes weekly for the secondary schools.

More stress should be placed on developing fitness for everyone rather than just those who have the ability to make varsity teams.

IN RECREATION. All existing facilities in the community should be put to use including the schools, churches, parks, athletic clubs, and other private and public facilities. It is because we lack facilities that so many people are denied opportunity for physical activity in recreation programs. Unorganized play in streets and vacant areas is not the answer to this problem. We must provide trained leadership, more funds, and more facilities to give directed physical activity in recreation programs.

GROUP DISCUSSIONS

Almost all groups agree that children should have daily physical activity in the physical education program for approximately one hour each day. However, the senior high boys' group points out that inadequate staff and facilities block this plan.

Elementary and secondary groups both believe that we must depend partly upon out-of-school daily living activities to help maintain and develop physical fitness.

How Can We Evaluate Physical Fitness?

SPEAKERS

Several tests are available with which to measure physical fitness. Some of these have been scientifically validated whereas others have been presented without objective evidence of validity.

Not all physical fitness tests measure the same kind of physical fitness. The evidence is that these tests do not correlate very highly. Therefore, it is necessary, when selecting a fitness test, to pick one that measures the kind of fitness wanted in the program. Because test results can only reflect the factors measured in the test, it is necessary to choose a test that measures the kind of fitness sought.

It is clear that simply showing improvement on test scores does not prove that the group increases in the type of fitness that they need. This matter can be cleared up only after it is demonstrated that the test chosen measures the type of physical fitness for which the program is planned.

Various groups throughout the country have acted to select physical fitness tests. Oregon recommends the use of the Kraus-Weber test up to the age of 11 or 12 and the PFI test after 12. The YMCAs have certified its leaders to give the Kraus-Weber test. On the other hand, California rejects the Kraus-Weber test saying that it is misnamed.

GROUP DISCUSSIONS

By their comments, all groups show that they recognize the importance of using only good tests which have been demonstrated to validly measure physical fitness. Only one group recommended a particular test by name.

The secondary girls group suggests that we need

to measure more than just one type of physical fitness, and therefore need more than one type of test.

The senior high boys group criticizes the procedure of planning a program on the basis of physical fitness tests. Instead it would figure out what kind of fitness is needed and then plan the program on that basis. The group recommends that only tests be used where validity has been demonstrated.

Comment

Reaction to the Conference was favorable. In letters sent in following the Conference, teachers expressed thanks for the chance to share ideas about physical fitness and to learn from others.

However, it is clear that *no problems* were solved as a result of the conference and that there is much we do not know about physical fitness and its value to the people of this country. The speakers urged the need for more study and more research to answer some important questions. Here are a few especially important questions that remain to be answered.

1. At what time of life is physical fitness most important?
2. What is the relationship between physical fitness and the general capacity to perform?
3. Can physical fitness help a person live longer?
4. Is the best fitness the most you can attain?
5. What level of physical fitness does living in our contemporary society demand?
6. What are the most effective ways of measuring physical fitness?

"From Other Journals"

H. JACKSON BURROWS, "Fatigue Infraction of the Middle of the Tibia in Ballet Dancers," *Journal of Bone and Joint Surgery*, 38B: 83-94, February, 1956.

Several cases of a lesion about the middle of the tibial crest of one leg have been observed in healthy young ballet dancers. Pain at a take off was noticed first, followed by tenderness and a palpable lump. Pain was never present during rest. The most obvious radiological finding was a horizontal fissure extending into the cortex of the tibial crest. It was concluded that these were fatigue infractions. Four patients improved with rest, but a proper assessment will be possible only with the lapse of more time. When diagnosis seems reasonably certain the best treatment may be immobilization in a long walking cast incorporating the knee and foot. The fact that all but one patient were males may be due to the fact that boys take up ballet later than girls, that they have to carry their partner's weight in addition to their own, that their legs are heavier and the inertia greater, or that their half-points position throws more strain on the calf than does the danseuses position.

—PJR

GEORGE M. PERSOL, "The Doctor Shortage in Physical Medicine," *American Journal of Physical Medicine*, 35:5-11, February, 1956.

Rehabilitation is a philosophy which implies that the community, the family, the physician and ancillary medicine groups have not fully met their obligation to the patient until he is restored to the fullest possible degree of useful and productive living. Rehabilitation programs will need continued expansion as the number of chronically ill and disabled groups in the country increases. The most pressing problem is to furnish more physiatrists. The increasing number of individuals trained in the technical aspects of Physical Medicine is no solution to the problem, since by law their activities must be supervised by a physician. The American medical profession as a whole regards Physical Medicine with little enthusiasm. In a survey by the A.M.A. only 0.6% of a large group of physicians expressed a desire for instruction in P.M. & R. The fundamental reason is due to the fact that it is not given adequate attention in our medical schools. Other objections are that its practice consists largely of referred patients; most of the treatment of patients is delegated to others; it does not lend itself well to private practice except in large cities; it requires a large financial outlay for therapists and equipment, and the financial returns are less than in certain other fields of medicine. If the need for physicians in Physical Medicine is not overcome in the near future, it may be met by non-medical cults, greater reliance upon technical groups, and by physicians in other fields directing the rehabilitation of their patients.

—PJR

JOHN H. ALDES, "Ultrasonic Radiation in the Treatment of Epicondylitis," *GP*, XIII: 89-96, June, 1956.

Epicondylitis is a syndrome characterized by pain in the lateral condyle of the elbow. The pain is accentuated by active motions of the extensor muscles that originate in the lateral epicondylar region of the humerus and radiate down the forearm to the wrist and hand. It is accentuated by pronation and supination of a fully extended elbow. Epicondylitis has been referred to as "tennis elbow," "pitcher's elbow," "golfer's elbow," "badminton elbow" and "squash player's elbow," but it also occurs among such occupational groups as housepainters, bricklayers, carpenters, welders, plumbers, machinists and housewives. The major factor in typical epicondylitis is the tearing between the tendinous origin of the extensor carpi radialis brevis and communis and the periosteum of the lateral epicondyle. The best results in treatment were obtained by the use of hydrocortisone injections into the lateral epicondyle followed by ultrasonic therapy to that area and to the extensor area of the forearm.

—PJR

JAMES B. ALLISON, "Evaluation of Dietary Proteins," *Nutrition Reviews*, 14:130-131, May, 1956.

Some investigators recommend the feeding of relatively high protein intakes to develop the labile protein stores maximally in order to correct dietary error or to meet the stresses and strains of daily living. The primary purpose of a dietary protein is to provide a pattern of amino acids appropriate for the synthesis of tissue proteins and for other metabolic functions. Amino acid requirements are influenced by a number of variables, many of them unknown or little understood. Present data suggest the ideal protein would be nearly like the composition of human milk or egg protein. A proper balance between calories and protein is of great importance. The goal of proper nutrition should be to produce a proper balance of amino acids, the intake of both nitrogen and calories being adjusted to produce an optimum development of lean body mass. The search is not for more protein in the diet but for a group of protein sources that combined will provide amino acids in proper amounts and ratios.

MAX M. NOVICH, "A Physician Looks at Athletics," *Journal of the American Medical Association*, 161:573-576, June 16, 1956.

The team doctor has two functions: (1) to prevent injury whenever possible and (2) to treat such injuries as occur so that the players achieve maximum physical restoration. He is responsible for the medical history, physical examination, conditioning, proper uniforming (in cooperation with the coach), treatment, follow-up, and attendance at all events where injury hazard is pronounced. Participants in boxing, wrestling, football, lacrosse and other sports that subject the head to blows should have an ECG before, during, and after the sports season. Boxing should be forbidden to the severely myopic. Mouthpieces should be worn in contact sports. Numerous congenital and acquired orthopedic, neurological and cardiovascular conditions constitute grounds for disqualification for athletic participation. Conditioning is of primary importance in preventing injuries. Proper protective equipment and any indicated special paddings must be worn. The basic principles of the treatment of athletic injuries should be followed. A contestant who has been ill or injured should be readmitted to participation only on the written approval of the physician. First aid for boxing and football should be administered only by the physician.

PJR

MAURICE E. LINDEN, "Fate, Feeling and Fantasy in the Development of Personality," *Journal of the Indiana State Medical Association*, 49:519-524, May, 1956.

In our culture aging is resisted, resented and denied; most of our values are youth-oriented. As a society we are progressively diminishing the importance and worth intrinsic in human relations. Values in human life other than sexual receive too little attention. But there is no prime of life; there are primes of life. Early life is largely instinctive. During the period of child raising the human psyche becomes socially creative. When the period of child bearing ends, the parents become state creative, in which they assume responsibilities for the welfare of future generations. Psychologically, the last stage of maturation is one of reflective examination, the sage of wisdom. The developing child develops feelings of hostility against his elders; even the young adult seeks to thrust the envied elder aside. These feelings of elder-rejection are suppressed. With age some of the defense mechanisms crumble, and the feelings of elder rejection may develop into self-rejection. Senility becomes childhood in reverse. Our society must be reeducated to rediscover the social values of the senescent and their enormous potential.

PJR

C. A. ROBBINS, "Two Deaths in Long-Distance Runners," *Journal of the American Medical Association*, 161:392, May 26, 1956.

On Nov. 26, 1953, in Manchester, Conn., a 20-year old cross country runner collapsed shortly before the finish of a five mile road race. He died 48 hours later. Autopsy revealed occlusion of the left internal carotid artery. On June 18, 1954, in St. Louis, a 29 year old runner collapsed after finishing a six mile race on the track. He died nine days later. Autopsy revealed diffuse liver damage due to hepatitis. Neither of these tragedies could have been averted by routine physical examination before the races. These casualties are the only two the author has heard of in 20 years of studying long-distance running.

M. R. CHANCE, A. J. LUCAS AND J. A. H. WATERHOUSE, "Changes in Dimension of the Nuclei of Neutrons With Activity," *Nature* 17:1081-82, June 9, 1956.

Changes in the dimensions of the neurone nuclei in the cerebral tissue of mice were measured after certain procedures. After anaesthetics or drug-induced convulsions the nuclei were smaller in diameter than in resting mice. After running or swimming they were larger.

PJR

Editorials

EDUCATIONAL GOALS IN REHABILITATION

A recently published article* contains the opinions of the then President of the Congress of Physical Medicine and Rehabilitation in regard to "Educational Goals in Physical Medicine and Rehabilitation." In this article, Dr. Gordon Martin critically examines the existing education of medical and lay personnel in the rehabilitation field, and offers suggestions for alleviating the various discrepancies which he discerns. Dr. Martin has seen fit to include the corrective therapists in his discussion of "the education of auxiliary personnel" and after reading his statements we believe that certain misconceptions should be clarified.

In the first place, statements that corrective therapists "are tending to develop their educational programs without relation to medicine;" and "that educational programs for them are not recognized by the Council on Medical Education and Hospitals of the American Medical Association" carry the inference that our organization seeks to arrogate responsibilities which have been delegated to professional medical groups. These statements fail to consider this association's long concern for professional standards for corrective therapists and its steadfast attempt to interest official medical groups in this problem. The failure of both the A.M.A.'s Council on Medical Education and the Congress of Physical Medicine and Rehabilitation in providing guidance in this respect was the cardinal reason why this association adopted a plan for setting educational standards for corrective therapists. This plan placed certification of therapists under the jurisdiction of a certification board which included prominent physicians as well as representatives of allied professions as members of the board. It was instituted to safeguard, insofar as was possible by the limited authority of this group, educational standards and training for corrective therapists.

In the same way this association has found it necessary to define the field** and scope of corrective therapy, to develop a code of ethics for the profession, and to aid in every way possible the establishment of curricula for corrective therapy students in various colleges and universities. Again, these steps have been necessary because guidance from established medical sources has not been forthcoming. However, it should

be pointed out that from the very beginning, our association has been most fortunate that many physicians prominent in the field of rehabilitation and other specialties have seen fit to interest themselves in the development of our profession and to give us the benefit of their guidance and counsel. Past accomplishments could hardly have been effectuated without this assistance.

It is our sincere belief that Dr. Martin's overall critique of the educational picture of rehabilitation personnel serves an important purpose, and we earnestly support the general philosophy which he has expressed in this article. We are impressed by his closing remarks in regard to the education of auxiliary personnel in which he states, "if auxiliaries are properly trained, we physicians will make use of them, and therefore we should stand ready to guide their educational efforts." We trust that Dr. Martin's colleagues will see fit to act upon his advice in this regard.

*Martin, Gordon M., "Educational Goals in Physical Medicine and Rehabilitation," *Archives of Physical Medicine and Rehabilitation*, 37:10:601-602, October, 1956.

**As defined by the Association for Physical and Mental Rehabilitation, *Corrective Therapy is the application of the principles, tools, techniques and psychology of medically oriented physical education to assist the physician in the accomplishment of prescribed activities.*

ERRETT C. ALBRITTON, "The Six Unities in Medical Research," *Journal of the American Medical Association*, 161: 328-333, May 26, 1956.

The medical practitioner needs to have a command of the principles of experimental method. Every simple experiment has two variables: the agent and the affected. To prevent errors the six unities must be observed. There must be (1) Identity or near identity between the average and range of time prevailing for the variables. The "before and after experiment" lacks unity of time if all measurements are made in the same sequence. (2) Identity or near identity of place. A difference of locality may affect the outcome. (3) Identity or near identity of material. The average and the range of any given characteristics for the two groups must be similar. (4) Identity or near identity of procedure. The differences in procedure which constitutes the experiment are of course excepted. Medical ethics may block unity of procedure in many clinical investigations. In "before and after experiments" reversal of sequence is not possible if the therapeutic agent makes a permanent change in the material. (5) Identity or near identity of personnel. The difference in researchers rather than the difference in treatments may be a cause of the result. (6) Identity or near identity of the mental attitudes. Attitude of the subject toward the treatment may affect the results. When writing the report the reader is entitled to the author's evaluation of the effect of violation of any of these unities.

PJR

Book Reviews

"Postural and Relaxation Training in Physiotherapy and Physical Education," by John H. C. Colson, (Springfield, Ill.: Charles C. Thomas, 1956. 105 pp. \$2.50)

The author of this little book is said to have "been responsible for the training of by far the greater portion of the remedial gymnasts" in England. In this volume he gives exercises and games designed to improve posture but emphasizes that their success depends upon whether or not the corrections thus induced become habitual with the subject. Relaxation techniques for neuromuscular tension are described, and a chapter on "So-Called Psychosomatic Tension States" is contributed by Maurice J. Parsonage. The book is written very simply and will be of use primarily to teachers in the primary schools. It is too elementary to be of much value to corrective therapists, who will find the same publishers' **The Diagnosis and Treatment of Postural Defects** (reviewed here May-June, 1956) much more valuable.

—PJR

"Conquest of Disability," Edited by Ian Fraser. (New York: St. Martin's Press, 1956. 224 pp. \$3.75)

Regular readers of this column will recall the review of **Champions by Setback** published in the May-June, 1956 issue. This book is much the same sort of thing. These are stories—many of them told first hand—of men who overcame some sort of severe handicap and went on to lead notably successful lives. With the exception of Franklin Roosevelt, nearly all the subjects are from the British Commonwealth. This sometimes creates semantic difficulties for the American reader. To read that a man expected "to get his 'cap' for England at Rugby football" or that "he gained 'firsts' in both parts of the History Tripos and a distinction, being the only candidate so placed in Part II" conveys no definite meaning to this reviewer. The book is well written and deserves a place in the "inspirational" section of hospital libraries. Since the majority of the cases recounted are the result of injuries received during World War I or II, it might be especially suited for V.A. hospitals. American readers may be astonished at the way the British Army permits disabled individuals to remain in the service. They seem to make far better use of their available manpower than is true of the American forces.

—PJR

"Professional Rehabilitation," by Fernando Boccolini. Sao Paulo: Social Service of Industry, 1956, Mimeographed, 59 pp.

This is a report on the status of rehabilitation in Brazil presented by the head of the rehabilitation service of the Social Service of Industry at the III Congress of Labor Medicine held at Caracas, Venezuela in November, 1955. In Brazil general acceptance of the concept of rehabilitation has been delayed by a series of obstacles—among them the low educational level of the workers, the promotion of habitual idleness by disability benefits, and the lack of qualified therapists. However, definite advances have been made and the future appears promising. Readers of this *Journal* will be especially interested in the references to medical gymnasts whose specialty includes the use of progressive resistance exercises, adapted sports and other activities which in this country are the province of the corrective therapist. It would be advantageous if some sort of international agreement could be reached on the term by which such individuals are designated and for the exchange of information between them.

—PJR

"Acute Head Injuries in Boxers," by L. E. Larsson et al. (Copenhagen: Ejnar Munksgaard, 1954. 42 pp. 15 Dan. Kr. Paper)

This monograph reports an EEG study of boxers made at the Swedish amateur championships in 1950 and 1951. It is one of the most valuable papers on the subject yet published. The authors acknowledge two technical difficulties: there is no strict parallel between EEG findings and clinical signs of brain concussion, and the exercise alone produces EEG changes. Granting these difficulties, the observations made in cases of knockouts and knockdowns were similar to those made in cases of slight concussion of the brain. The authors conclude that a knockout is due to cerebral lesions of the concussion type. Blows to the lower jaw may be especially effective because the forceful rotation of the head produces shear strains which are the essential cause of brain concussion and cerebral contusions. The problem of determining the potential danger of cerebral damage during an amateur boxing career is an extremely difficult one, and the EEG is of only limited value in solving it. The authors do not recommend that boxing be banned, but they do urge more careful supervision of the sport, including the debarring of injured fighters. An excellent bibliography concludes a report that will be of great interest to anyone connected with athletics, especially boxing.

—PJR

"Studies in Topectomy," Edited by Nolan D. C. Lewis, Carney Landis and H. E. King. (New York: Grune & Stratton, 1956. 248 pp. \$6.75)

This small monograph describes a series of studies by the New York State Associates in Brain Research. It is a continuation of the work started in 1949 by the Columbia-Greystone Associates and follows the second Columbia-Greystone research project, brief summaries of which are given. In the words of the editors, "this monograph may best be considered as an interim report, based primarily on the first two years of the study made by the New York State group." Each of the investigators is an authority in his field and is well qualified for the specific type of study involved. The surgical procedures wherein a block of cortical tissue is removed bilaterally from the frontal lobes are described. The two operations which were researched in this particular project are the orbital and the superior topectomy. Both physiological and psychological reactions of the patients, pre- and post-surgically, are covered. The volume closes with a section on social service problems as related to the patient who has undergone topectomy. To the scientist interested in the techniques of and results obtained by topectomy this book will provide a fascinating and authoritative reference. The complexity of the study and the number of investigators involved, as well as the varied areas investigated, indicate that this work will be considered an outstanding research monograph in the field of psychosurgery. For those interested in the organic versus the dynamic etiology of behavior, this volume will perhaps both answer some questions and provide additional stimulation for further speculation regarding the etiology and neurophysiological mechanisms of behavioral reactions. Index and references are complete.

—DCL

"Artificial Limbs," Advisory Committee on Artificial Limbs. (Washington 25, D.C.: National Academy of Sciences—National Research Council, Spring 1956)

Since this magazine is now published only twice a year, it is treated here as a book rather than a periodical. The current issue is devoted principally to the skin hygiene problems of the amputee. These generally demand dermatological or surgical care. While corrective therapists must be aware of the skin conditions which can result from improperly fitted prostheses and other causes, they will have only an indirect interest in the contents of this issue.

—PJR

"Physical Conditioning," Air Force Manual No. 160-26. (Washington, D. C.: Government Printing Office, 1956. 163 pp.)

The physical conditioning program of the Air Force is designed to accomplish four things: develop physical fitness, encourage regular exercise, foster team spirit and teach survival aquatics. The purpose of this manual is primarily to aid base or unit commanders in setting up such a program. After an introduction which stresses the importance of physical training, a large section—approximately half of the text—is devoted to describing various activities, their advantages, disadvantages, space and equipment requirements, etc. Chapters on teaching techniques and evaluation procedures conclude the manual. For the most part only a few movements are described for each activity, and these are profusely illustrated.

Unfortunately, several highly dubious techniques are depicted in the section devoted to weight training. On p. 92 the exercise is labelled "High Pull-Up," but the description is that of the military press done from an incorrect starting position. It is to be devoutly hoped that no reader attempts to snatch a heavy weight from the starting position shown on p. 95; this will practically guarantee lower back trouble. In the supine press (p. 96) the knees should be bent so that the feet are in position to resist the occasional tendency to tip off the bench. Use of the fully extended arms shown in the "flying exercise" (p. 102) is certain to produce soreness in the elbow areas for most men.

The reading of texts on physical fitness always raises questions of evaluation. Precisely how much do certain exercises, such as pyramid building, contribute to the desired goals? How successful are programs of this type in inducing a desire for regular exercise? (Most of the aviators the writer knew during World War II had been exercised to the point that they hated the very sound of the word.) What is the relationship of physical fitness to success in flying? What percentage of a military man's time should be devoted to physical training? Which exercises will give us the desired results in the shortest time? Once a man is trained, how much work does it keep to maintain him at a satisfactory level of fitness? Until such questions can be answered, physical education for military personnel cannot be said to rest on a scientific basis.

—PJR

"Management of Emotional Problems in Medical Practice," edited by Samuel Liebman. (Philadelphia: J. B. Lippincott Company, 1956. 152 pp. \$5.00)

This small volume is directed primarily toward the general practitioner who wishes to have additional information regarding some of the more common problems of the emotionally disturbed patient in clinical practice. It consists of nine sections and is a compilation by editor Liebman of a series of selected lectures. The lectures cover: **Psychiatric Emergencies**, Karl Bowman; **The Use and Abuse of Sedatives and Stimulants**, Frances Gerty; **The Management of the Anxious Patient**, Lewis Robbins; **The Depressed Patient**, Franklin Ebaugh; **The Management of Emotional Reactions in the Male Involutional Period**, Otto Billig; **Management of the Multiple Complainer**, George Ham; **Management of Overeating, Overdrinking and Over-smoking**, Leo Bartemeier; **On Avoiding the Production of Iatrogenic Disease**, Walter Alvarez; and **The Utilization of Community Resources in Medical Practice**, Marc Hollender. This should not be considered as a text in psychiatry but rather a series of talks on some of the more commonplace problems. Although this reviewer is not in accord with all of the material presented, it is recognized that the general practitioner may find much of value as regards certain psychiatric problems common to general practice. The authors are authorities in the field of psychiatry and have special interests in the particular subjects which they present in this brief volume. The index is complete and the book should provide a ready reference for the general practitioner and other individuals who may have contact, at various times, with the emotionally disturbed individual.

—DCL

"Migration and Mental Disease" by Benjamin Malzberg and Everett S. Lee. (New York: Social Science Research Council, 1956. Paperbound. 142 pp. \$1.50)

This scholarly monograph reports part of the efforts and experience of the Social Science Research Council's Committee on Migration Differentials in effecting a revision of the **Research Memorandum on Migration Differentials** published in 1938 as Council Bulletin 43. The authors review in a most interesting and helpful way a portion of the pertinent literature pointing to some of the earlier insights as well as the methodological weaknesses which have influenced the project reported in a later portion of the book. The focus of the monograph is on demonstrating a methodology whereby data presently available in most mental hospitals can be used meaningfully in conjunction with U.S. Bureau of the Census information. Several sections are devoted to discussion of problems and weaknesses encountered in the present methodology. The methods are applied to a limited sampling consisting of first admissions to the New York State hospitals for mental disease from July 1, 1938 to June 30, 1941. Analyses are based on several varying definitions of "migrant" and "nonmigrant" with age, sex, color or race held constant. Migrants first are defined as foreign born, redefined for a second analysis in terms of state of birth, and then a third analysis is undertaken with time at which the migration occurred being considered. All psychoses are grouped initially for each analysis and separate studies are then made for schizophrenic, manic depressive, and "other" groups of psychotic patients. Findings for each analysis are discussed and related to some of the findings reported in prior literature.

The reviewer considers this monograph to be excellent and enlightening reading for those people who do not ordinarily read publications in this area. The introductory section is exceptionally well done and gives good feeling for the work which has preceded. A major contribution is that of pointing out the difficulties in undertaking this kind of research and of offering hope for those who have been disheartened by the obvious difficulties of such an approach or of work in such an area. It is lacking as a methodological model since the authors have attempted no statistical test of the probabilities that observed differences reflect real differences. To have included statistical evaluation, if only to demonstrate the use of these methods, would have increased the usefulness of the application sections of the monograph. There is some ambiguity in portraying the data because of a somewhat inadequate explanation of the semilogarithmic charts used and the absence of labeling for the tables explaining the data in the migrant rate tables. The monograph has aroused interest in the present reviewer in both the earlier work reviewed and in the promised revision of the **Research Memorandum of Migration Differentials**.

—JS

"The Mentally Retarded Patient," by Harold Michael-Smith. (Philadelphia: J. B. Lippincott Company, 1956. 203 pp. \$4.00)

This brief volume by a Ph.D. in psychology presents material that is complete and serves as an excellent outline for the study of the mentally retarded individual. Michael-Smith's basic premise is that the mentally retarded patient is suffering from a loss rather than a lack, in that the retardation is due to the blocking of neurological connections rather than the absence of such connections. The entire text is based on this premise, and a clear exposition of his concept is given in chapters covering "The Role of the Physician," "Brain Impairment," "Learning and Emotional Factors" and "Classification of Mental Retardation" (based upon the work of Lawrence B. Slobody, Director of Pediatrics at the New York Medical College). The importance of "Attitudes Toward Prevention and Etiology" of mental retardation is equally ably presented as is the "Psychological Examination" of the patient. Problems of family adjustment, education, vocational prognosis and the future as related to diagnosis and treatment of such conditions complete the book. This is an excellent volume for the physician, lay person, parent or medical student. It clearly covers the material in the field of mental deficiency and

integrates a pattern of understanding and treatment into a comprehensible whole. A bibliography for professional workers in the field, an appendix listing the state and private institutions caring for the mentally retarded child, and an index make this a necessary acquisition for the library of anyone interested in the study of the mentally retarded.

—DCL

"Psychology—General-Industrial-Social," by John Munro Frazer. (New York: Philosophical Library, 1956. 310 pp. \$7.50)

This is a British book "designed to provide an introduction to general psychology and to illustrate its application in dealing with the human problems of industry and commerce and the management of social groups." In the U. S. each of the subjects in its title would require at least a one semester course, each utilizing a text as large or larger than this one. Obviously, a great deal of compression of material has taken place. There are almost no citations to the literature, the bibliography is extremely sketchy, and some of the statements are over-simplified. However, it does provide an acceptable overview of the three fields in question. A summary in question-and-answer form follows each chapter. There are some illustrations and an index is provided. The occasional references to the British Army techniques, such as the organization of men of limited intelligence into Unarmed Pioneer Companies, suggest that the British Army often utilizes its manpower much more efficiently than does its American counterpart. This book will be useful to the foreman or other supervisor who has not had academic training in psychology but who desires a working knowledge of its findings as applied to dealing with people. They may, however, be deterred by the price.

—PJR

"Alcoholism," Edited by George N. Thompson. (Springfield: Charles C. Thomas, 1956. 554 pp. \$9.50)

In spite of the continued appearance of literature on the problem of alcoholism, the reviewer knows of no medical monograph previously published on this subject. In this book eleven contributors have collaborated to produce a single volume covering nearly all aspects of the problem. Chapter One deals with the public health and social aspects. The next three chapters offer a concise coverage of the pharmacological and pathological aspects of alcohol and alcoholism, with a chapter on alcohol and brain physiology. This leads naturally into the questions of alcoholism in internal medicine, neurology and psychiatry. The final chapter presents the special role of electroencephalography in alcoholism. As Thompson states in the preface, "We have been saying that 'alcoholism is a disease', but we have continued to act as if the alcoholic were a criminal." Most physicians are too busy to devote adequate attention to the time-consuming problem drinker. The lay worker is often poorly informed or prejudiced in his viewpoint. All too often the alcoholic is driven further into his difficulties. However, the advent of the group therapy movement of Alcoholics Anonymous has pointed to one way of salvation for these unfortunates. This book is a must for anyone concerned with the problem, actual or potential, of alcoholic excess.

—MLB

Books Received

"Educating Spastic Children," by F. Eleanor Schonell. (New York: Philosophical Library, 1956. 242 pp. \$6.00)

"Women of Forty," by M. E. Landau. (New York: Philosophical Library, 1956. 49 pp. \$2.50)

A brief monograph on the menopause, written for the lay reader.

"Adaptation in Pathological Processes," by William H. Welch. (Baltimore: The John Hopkins Press, 1937. 58 pp. \$1.50)

This little book was published 20 years ago, and its text is a speech given in 1897! The explanation is that it is an item in the Johns Hopkins Publications of the Institute of the History of Medicine. The text is as pertinent now as it was when given. Probably everyone connected with adapted physical education has participated in discussions as to whether certain adaptation shown by his patients were purposeful or harmful. Welch's answer is forthright: "I believe that it can be shown that most pathological adaptations have their foundations in physiological processes . . . This adjustment is usually, wholly or in part, advantageous to the individual; but it is not necessarily so, and it may be harmful." He then discusses heart hypertrophy as an example of the mechanism of adaptation. A general theory is developed: "cells are incited to growth through removal of obstacles to growth in consequence of some disturbance in the normal relations or equilibrium of the cells with surrounding parts," and, in the true scientific spirit, its weaknesses are discussed. This is an excellent book and should promote thought in every professional reader. In spite of its age it is a must item for every C.T. library. Those finding the subject interesting would do well to look up another old item, Lewis & Grant, "Vascular Reactions of the Skin to Injury," *Heart*, 11:209, 1924.

—PJR

"A Follow-Up Study of War Neuroses," by Norman Q. Brill and Gilbert W. Beebe. (Washington, D.C.: United States Government Printing Office, 1956. 393 pp.)

The work reported in this Veterans Administration Medical Monograph is a part of the program of studies of the Follow-up Agency of the National Research Council. The material presented is an examination of the present knowledge of psychoneurosis as applied to the military setting. The results of selection, preventive efforts, treatment and rehabilitative procedures are covered. Included is an evaluation of screening criteria, assignment methods and treatment programs. The volume consists of five major parts: (1) The Basic Findings, (2) An Analysis of Follow-up Data Covering Disability, (3) Analysis of Military Experience, (4) An Analysis of Preservice Period and (5) Implications for Induction, Utilization and Disposition Policies. The Appendices cover the various forms used. This volume should prove to be of value to the psychiatrist and to the interested lay person, as well as to students of research methods and statistics. It is without doubt the most complete work in its field. There are 271 Tables and 11 Figures to cover the statistical breakdown of the material revealed by the above research. The Index is complete and provides a source of ready reference for those interested in statistical material on follow-up studies of war neuroses.

—DCL

"The Biosocial Nature of Man," by Ashley Montagu. (New York: Grove Press, 1956. 123 pp. \$1.00. Paper)

Montagu denies the Darwinian theory that man inherits the aggressiveness of his animal ancestors and the Freudian theory that destructive tendencies are present in all men. Aggressive behavior, he says, is a purely cultural phenomenon—aggression is the expression of an unfulfilled need for love. Human nature is the result of interaction between biological endowment and environment. Racial differences simply reflect cultural experiences. Crime is socially not biologically produced; hence there are no constitutional factors characteristic of criminals. In education, then, lies the hope for man's future. Montagu's optimistic view of man as a cooperative creature is well known and this adds nothing new to what he has already written. To some of us he seems to oversimplify the problems, but he writes beautifully and his message is one of hope. The book is recommended reading.

—PJR

News and Comments

START NEW RESEARCH ON MENTAL ILLNESS

A new type of research program, aimed at finding possible chemicals in the body that may play a role in the production of some forms of mental illness has been launched at the Veterans Administration hospital on Leech Farm Road in Pittsburgh, Pa. Dr. Amedeo S. Marrazzi, director of the VA Research Laboratories in Neuropsychiatry, located at the Pittsburgh hospital, said his group will study disturbances in brain function which could result from a disorder in metabolism of the brain—how it uses energy supplied by food. The study will give a better understanding of normal and abnormal brain function, he said. This new VA venture will be among the few of its kind in the United States, Dr. Lee G. Sewall, manager of the hospital, said.

Dr. Marrazzi explained that sometimes the body, by its disturbed metabolism, may produce chemical reactions which interfere with the messages that are transmitted from the brain along the pathways of the nervous system for muscle movement and all forms of human activity.

The Pittsburgh Laboratories will study the operation of the brain in mentally ill persons, primarily those with schizophrenia or "split personality," and also in normal persons to determine what blocks or distorts these messages.

SPEED UP ON ORTHOPEDIC SHOES

A new system of handling orthopedic shoes which provides better service to veterans and saves taxpayers about \$50,000 to \$60,000 per year has been announced by Veterans Administration.

Centralizing orthopedic shoe services in New York City results in quicker and more satisfactory repairs and saves approximately \$12 per pair on the 5,000 to 6,000 pairs of new shoes furnished veterans with foot disabilities annually, according to Dr. C.F. Miller, chief of the prosthetic appliances and accessories section.

AMVET AWARD TO RUSS WILLIAMS

A blind veteran who has dedicated his life to helping others who have lost their sight received the National Rehabilitation Award, highest honor of the American Veterans of World War II (AMVETS) on December 14. He is Russell C. Williams, chief of the unique rehabilitation center at the Veterans Administration Hospital at Hines, Ill., where sightless veterans are taught to "see" with the walking cane and become independent, useful citizens again.

AMVETS national service director John R. Holden of Washington, D. C., presented the award in a ceremony at AMVETS Post 80, 2408 West Division St., in Chicago, attended by more than 300 veterans and government and civic officials.

Mr. Williams is a native Chicagoan who was blinded by an exploding shell in France in World War II. A gangling, fast-walking man who looks somewhat like Abe Lincoln, he has helped 384 sightless veterans toward a new life during the 16 weeks of training each received at the Hines VA center. In April this year, he represented VA at the two-week world-wide seminar on rehabilitation of the blind held in London, England. He is a central figure in the VA training film, "The Long Cane," which has been distributed and shown nationally to demonstrate techniques used at the Hines center to rehabilitate the blind. Before joining VA when the Hines center was opened in 1943, Mr. Williams served as special counselor to blinded soldiers in the Army.

Mr. Williams received the Rehabilitation Award of the Association for Physical and Mental Rehabilitation in 1955.

NEW TB RESEARCH UNDERWAY

Research aimed at learning how tuberculosis germs get into the lungs of uninfected persons and what may be done to prevent it is underway at the Veterans Administration hospital in Baltimore, Md. The research is being conducted by Dr. Richard L. Riley, associate professor of environmental medicine at Johns Hopkins University School of Hygiene and Public Health, as principal investigator, in association with William Firth Wells, a well-known expert on airborne infection and a VA consultant; Mrs. Cretyl C. Mills, bacteriologist, and Dr. Walenty Nyka, pathologist.

Dr. Ross L. McLean, director of professional services at the Baltimore VA hospital, said that although staff members and volunteer workers in VA tuberculosis hospitals are protected effectively from acquiring the disease, findings of the research project may be used to develop methods of protection more simple than the present techniques. Dr. McLean said all evidence points to the air breathed as the most important pathway for the TB germ to travel, either inside or outside a hospital. Studies with rabbits and using special laboratory types of tuberculosis germs have shown that only the tiniest of particles can carry the TB germ into the lung of an uninfected animal, Dr. McLean said. This was demonstrated by artificial contamination of the air breathed by the animals with tuberculosis germs borne upon particles of various sizes, he said.

Because the infectious particles are so tiny that they float around in the air like smoke, ultra-violet light treatment of contaminated air has been found effective in protecting experimental animals from this laboratory type of tuberculosis, according to Dr. McLean. "It is of the utmost importance to determine whether human beings with active tuberculosis of the lungs actually contaminate the air they breathe with the tiny particles that are so infectious for laboratory animals, because this may well be the most important way that infectious cases infest other persons," Dr. McLean explained.

To determine just how contaminated the air breathed by persons with active tuberculosis may be, approximately 200 guinea pigs will stay for many months in an exposure chamber where they will breathe air drawn from the rooms of patients. The number of animals which show evidence of tuberculosis and the length of the time the disease takes to develop will measure exactly the degree of contamination of air by patients.

ADVANCE NOTICE OF AN EXAMINATION IN INDIVIDUAL REMEDIAL PHYSICAL EDUCATION

The Division of Physical and Health Education of the Philadelphia Public Schools takes pleasure in announcing the initial examination for teaching individual remedial (corrective) physical education in the junior high, senior high, and vocational-technical schools.

Individual remedial (corrective) physical education in this city deals primarily with the improvement and/or correction of orthopedic defects with special emphasis placed on posture and foot deviations.

Candidates for this examination must be graduates of approved colleges or universities with majors in physical and health education. It is desirable that they have additional special study in remedial (corrective) physical education or physical therapy.

The date, time and place of the examination will be announced very shortly. For additional information write:

The Division of Examinations
Board of Public Education
Parkway at 21st Street
Philadelphia 3, Pa.

"If these guinea pigs contract tuberculosis in sufficient numbers, it will prove that human beings with tuberculosis of the lung produce the type of minute infective particles which already have been shown to be so highly infectious for the experimental animal," Dr. McLean said. "Once this fact has been established, new, more simple methods for protecting those who care for tuberculous patients may possibly be introduced to supplement or replace the presently used highly effective methods. Also, these results may lead to air hygiene research in other fields with broad implications regarding the protection of persons who may be exposed to infection in other ways outside the hospital."

VA INVESTIGATING HIGH BLOOD PRESSURE

High blood pressure, man's greatest killer, will be investigated through large-scale drug research, Veterans Administration has announced. Dr. Edward D. Freis of the VA Mount Alto Hospital in Washington, D. C., is coordinator of the program. He said the study is aimed at determining how well newer drugs control high blood pressure and whether they can prevent hardening of the arteries, heart attacks, strokes, and other complications of the disease. Six VA hospitals will carry out the research. In addition to Mount Alto, they are at Iowa City, Iowa; San Juan, Puerto Rico; Chicago West Side, and Richmond, Va., with a sixth still to be chosen.

Dr. Freis said the drugs under test are reserpine, which is a tranquilizer; hydralazine, a powerful dilator of blood vessels, and pentolinium tartrate, chlorisondamine chloride, and mecamylamine hydrochloride. The latter three are synthetic compounds that block transmission of nerve impulses to the blood vessels. When patients with high blood pressure are admitted to the six participating hospitals, evaluations of their conditions, including laboratory and X-ray procedures, will be made, Dr. Freis said. The patients then will be divided into three groups of mild, moderately severe, and severe cases, he said. In accordance with their medical needs, some patients will receive reserpine alone, others reserpine and hydralazine, and others reserpine plus another drug that blocks nerve impulses.

Dr. Freis said that after patients return to their homes, records of blood pressure will be taken daily and frequent visits will be made by the patients to hospitals where improvements will be checked. At the end of a year, patients will return to the hospitals where the various laboratory procedures will be repeated to determine the effects of the treatment, he said.

VA SETS NEW POLICY TOWARD AGED MENTAL PATIENTS

More efficient use of bed space in Veterans Administration hospitals has given VA the equivalent of another 1,700-bed mental hospital in the past four years. Dr. J. F. Casey, director of the psychiatry and neurology service at VA central office in Washington, D. C., said that approximately 1,700 beds have been freed in VA mental hospitals since August, 1952 by transfer of about 1,700 elderly chronic mental patients with physical illnesses to VA general medical and surgical hospitals that give special care to aged patients. Results of the transfers have been even better than were expected, probably because the staffs of the general medical and surgical hospitals were able to give more personal attention to patients than the smaller staffs of the mental hospitals had been able to give, Dr. Casey said.

The patients transferred to general medical and surgical hospitals were those whose mental illnesses had become stabilized and resistant to treatment over periods of 10 to 20 years so that their chronic physical illnesses were predominant, Dr. Casey explained. The transfers were part of a special VA program to provide a type of care and rehabilitation designed for elderly patients with chronic physical illnesses of many kinds.

DRASTIC REDUCTION IN SHOCK TREATMENT REPORTED

Electric and insulin shock treatment for mental illness has been reduced by an estimated 90 percent at Veterans Administration mental hospitals through use of the new tranquilizing drugs. In addition, the tranquilizers are permitting better treatment for mentally ill veterans, with the result that more patients can return home by discharge from hospitals and trial visits, Dr. Ivan F. Bennett, Chief of Psychiatric Research in the VA Central Office at Washington, D. C., said. The drugs enable VA hospitals to make more efficient use of personnel, since there is no longer a need to maintain teams of personnel in shock units. These personnel now can work directly with patients in their other activities, Dr. Bennett said. In addition, treatment with the tranquilizing drugs is less expensive than insulin shock treatment.

"However," Dr. Bennett said, "there still remain mentally ill patients in VA hospitals whose conditions cannot be relieved by the newer methods or who remain resistant to the effect of tranquilizing drugs. These patients, in order to have the best available treatments in modern psychiatry, are receiving shock therapies."

Tranquilizing drug therapy, like the older shock therapies, is not a cure for mental illness, Dr. Bennett said. He explained that the drug therapy results in such a degree of improvement in symptoms that patients are happier in their relationships with others, often are able to be at home with their families, and often can be gainfully employed. Dr. Bennett's estimate of an overall 90-percent reduction in electric and insulin shock treatment was made from a representative sampling of VA neuropsychiatric hospitals throughout the nation.

VA CITES REHABILITATION GAINS

Chronically ill and aged veterans, hospitalized 10 to 20 years, are being rehabilitated and discharged from Veterans Administration hospitals under an advanced concept of long-term patient care established by VA. Dr. I. J. Cohen, hospitals and clinics director in VA Central Office at Washington, D. C., said that since the new program was put into operation about a year ago 1,159 of the initial group of 4,263 chronic hospital patients have been discharged. "A concerted effort is made to rehabilitate these chronically ill veterans sufficiently for them to be returned to their homes, to a foster home, or to other appropriate community facilities," Dr. Cohen said. "Those for whom this is not possible continue to receive the care and treatment needed in as nearly a home-like atmosphere as it is possible to have in a hospital."

The program for long-term patients is aimed at providing for their needs after doctors have done all that is possible to cure their diseases, Dr. Cohen explained. Continuing medical care is part of the program, but emphasis is placed on preparing patients for return to their home communities or for living with as much independence as possible within the hospital, so that deterioration may be prevented or retarded, he said.

Dr. Cohen said if patients with heart and blood vessel disorders, diseases of the digestive system, arthritis and other chronic conditions are allowed to lie in hospital beds year after year with only routine care, the resultant deterioration is likely to become irreversible. "The VA program," he added, "is an all-out effort by every branch of the hospital staff to rehabilitate long-term patients so they may achieve the best possible physical condition and maximum self-help, and to provide them with recreational, spiritual, and social activities so as to prevent mental regression and social isolation." To provide this type of program, many VA hospitals have established special wards or sections for long-term patients and have made specific changes in their operations. It is expected that many more will do the same as staff members become available, Dr. Cohen said.

(Cont'd on Next Page)

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AGED MENTAL PATIENTS (Cont'd)

By grouping long-term patients on wards or sections, the hospitals are able to relax the rigid routine necessary on wards for acutely ill patients and to provide personnel especially trained in caring for the chronically ill, he said.

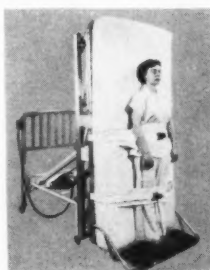
Dr. Cohen said volunteer assistance from communities in which VA hospitals are located is expected to be especially helpful in the program. Volunteers working in VA hospitals can bring new interests to long-hospitalized patients and help them re-establish associations with the outside world, he emphasized. All VA general medical and surgical hospitals and some VA tuberculosis hospitals are caring for patients of this type, but 49 hospitals have special wards or sections for long-term patients, Dr. Cohen said.

ANNOUNCE MENTAL HEALTH WEEK

The 9th annual observance of National Mental Health Week will take place from April 28 to May 4, 1957. The National Association for Mental Health and the National Institute of Mental Health are co-sponsoring the program.

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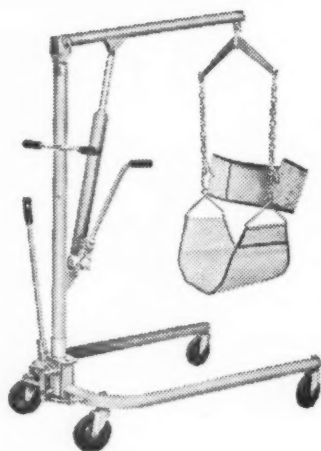
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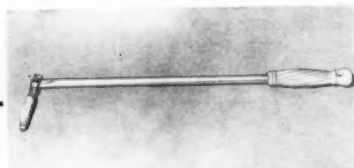
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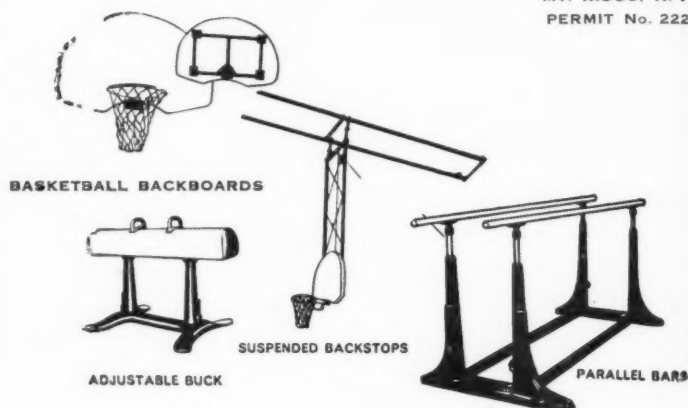
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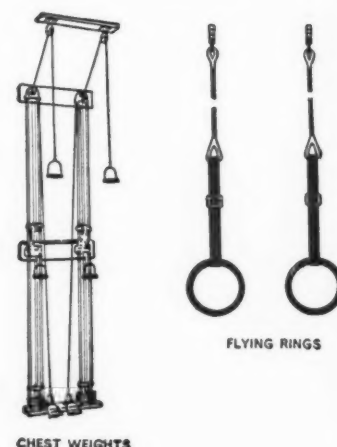
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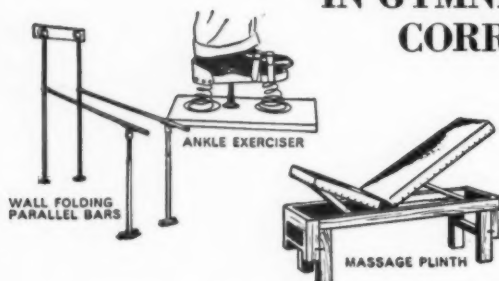
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